

REC'D MAY 9 1938

**MISSOURI STATE BOARD OF HEALTH**  
**BUREAU OF VITAL STATISTICS**  
**CERTIFICATE OF DEATH**

13790

Do not use this space.

## 1. PLACE OF DEATH

(a) County Jackson | Registration District No. 399  
 (b) Township Raw | Primary Registration District No. 1002  
 (c) City Kansas City (d) Street No. Research Hospital St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. 2 ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

Registered No. 17702. PRINT FULL NAME JAMES B. SCOTT 300

(a) Residence, No. Liberty, Mo. St.   
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Wilmina Scott

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
79

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 013. NAME 014. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 0

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 0

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE

19. FUNERAL DIRECTOR Brothers Drumm(ADDRESS) Brothers Drumm, Liberty, Mo.20. FILED Apr 26, 1938 M. M. Grooms  
Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 27, 1938

22. I HEREBY CERTIFY, That I attended deceased from 4-4, 1938, to 4-27, 1938

I last saw him alive on 4-26, 1938. Death is said to have occurred on the date stated above, at 1:55 am.

The principal cause of death and related causes of importance were as follows:

Acute Athero Sclerosis  
97

Other contributory causes of importance:

Hypertensive Pneumonia 4-20-38

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no  
If so, specify(Signed) Lawrence W. Grooms M. D.(Address) Research Hospital, N.O. Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FADING INK--THIS IS A PERMANENT RECORD

**STATEMENT BY LICENSED EMBALMER**

I, \_\_\_\_\_, Licensed Embalmer No. \_\_\_\_\_

hereby certify that the body recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_

\_\_\_\_\_ L. E. \_\_\_\_\_

No. \_\_\_\_\_ or by \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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CERTIFICATE OF DEATH

13790  
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No.....  
(b) Township..... Primary Registration District No.....  
(c) City..... (d) Street No. *Research Hosp.* St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

Registered No. *1770*

2. PRINT FULL NAME

(a) Residence, No. *James B. Scott* St.  *Liberty, Mo.*  
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Married*

21. DATE OF DEATH (MONTH, DAY, AND YEAR) \_\_\_\_\_, 19\_\_\_\_

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Sept 29 1858*

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said

7. AGE YEARS *79* MONTHS *7* DAYS *28* If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

to have occurred on the day stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Retired merchant*  
9. Industry or business in which work was done, as saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

Date of onset

12. BIRTHPLACE (CITY OR TOWN) *Plattsburg* (STATE OR COUNTRY) *Missouri*

Other contributory causes of importance:

FATHER 13. NAME *Josiah Allen Scott*

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

14. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

MOTHER 15. MARDEN NAME *Eliza Scott*

23. If death was due to external causes (violence), fill in also the following:

16. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

17. INFORMANT *Miss Nellie Scott* (ADDRESS) *Liberty Mo*

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

18. BURIAL, CREMATION, OR REMOVAL PLACE *Plattsburg* DATE *5/29* 19*38*

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

19. FUNERAL DIRECTOR *Brothers Jennings & Don Carlos* (ADDRESS) *Liberty Mo*

24. Was disease or injury in any way related to occupation of deceased?

If so, specify \_\_\_\_\_

(Signed) \_\_\_\_\_, M. D.

20. FILED *Apr 26* 19*38* *Dr. M. Browe* Local Registrar.

(Address) \_\_\_\_\_

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Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

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