

1939 AUG 11 1939

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

27176
Do not use this space.

1. PLACE OF DEATH
(a) County Wright 1 Registration District No. 908
(b) Township _____ Primary Registration District No. 4549
(c) City Mt. Grove, Mo. (d) Street No. _____ St.
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.
2. PRINT FULL NAME Miss Arlene Scott Bufford
(a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) divorced
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Phillip Bufford
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 26, 1886
7. AGE YEARS 52 MONTHS 4 DAYS 29 If LESS than 1 day, _____ hrs. or _____ min.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. housewife
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) Marshall, Mo.
13. NAME Allen Lee Van Scott
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.
15. MAIDEN NAME Arlene Bartlett
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn.
17. INFORMANT Albert Scott
(ADDRESS) Mt. Grove, Mo.
18. BURIAL, CREMATION, OR REMOVAL
PLACE Willert DATE May 26 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Russ Barber
Mt. Grove, Mo.
20. FILED 7-28 1939 Bessie Montgomery
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 25 1939
22. I HEREBY CERTIFY That I attended deceased from May 24, 1939, to May 25, 1939
I last saw her alive on May 24, 1939 Death is said to have occurred on the date stated above, at 5 A. m.
The principal cause of death and related causes of importance were as follows:
Cerebral Hemorrhage Date of onset _____
Other contributory causes of importance: g2k
Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____
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) W. A. Craig M. D.
(Address) Mountain Grove, 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.

RECEIVED

District Health Officer No. 6,

District File Number 839-1568

Date Filed AUG 9 1939

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

....., or by

Registered Apprentice No., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.)

If this body is not embalmed, above space should be left blank.