SEP 13 1939

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

29735
Do not use this space.

1. PLACE OF DEATH

(a) County Moniteau — Registration District No. 076

(b) Township or City Harrison — Primary Registration District No. 6773A — Registered No. 7

(c) City High Point - Rural (d) Street No. 350, 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. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Mary Ann Scott

(a) Residence, No. Enon, 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Female	White	Widowed

5A. IF MARRIED, WIDOWED, ~~OR DIVORCED~~ ~~HUSBAND OF~~ (OR) WIFE OF Samuel W. Scott

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 14th, 1851

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
87	11	24	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House maid

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) Marietta (STATE OR COUNTRY) Ohio

FATHER

13. NAME Robert Williamson

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

MOTHER

15. MAIDEN NAME Sarah Muscaratt

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio,

17. INFORMANT Jesse Scott (ADDRESS) Enon, Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Green Ridge Cem. DATE Aug 9th, 1939, 19

19. FUNERAL DIRECTOR (NAME) G. H. Steffens (ADDRESS) Russellville, Mo.

20. FILED 10-8, 1939 Jewell Phillips Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug. 8th, 1939, 19

22. I HEREBY CERTIFY, That I attended deceased from 7/30, 1939, to 8/8, 1939
I last saw h... alive on 8/6, 1939. Death is said to have occurred on the date stated above, at 5-15 A.M.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Paralysis	7/30/39
Other contributory causes of importance: Arterio-Sclerosis	2

Name of operation ..... Date of .....
What test confirmed diagnosis? Clinical 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) G. D. Wallace, M. D.
(Address) Eldon 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.

(Licensed Embalmer's Statement on Reverse Side)

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

G.N.Steffens, Registered Apprentice No.

working under my personal supervision.

Signed G N Steffens

Licensed Embalmer No. 2307

P. O. Address Russellville, Mo.

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

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

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

29730-X
Do not use this space.

1. PLACE OF DEATH
(a) County Moniteau — Registration District No. 576
(b) Township Harrison — Primary Registration District No. 5773 — Registered No. 7
(c) City ..... (d) Street No. ..... 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. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Mary Ann Scott
(a) Residence, No. ..... 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 F
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)
7. AGE YEARS 87 MONTHS 11 DAYS 24 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
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)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)
18. BURIAL, CREMATION, OR REMOVAL
PLACE ..... DATE 19
19. FUNERAL DIRECTOR (ADDRESS)
20. FILED ..... 19 ..... Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-8, 1939

22. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to ..... 19....
I last saw h..... alive on ..... 19..... Death is said to have occurred on the date stated above, at ..... m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
1. Paralysis	
Bulbar	7/30/39
81 W	

Other contributory causes of importance:
Arterio Sclerosis

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? .....
If so, specify .....
(Signed) G. D. Walker, M. D.
(Address) Eldon, Mo

SUPPLEMENTARY

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.