

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.

DEC 18 1939  
Registration District No. 467

Primary Registration District No. 4280

Registrar's No. 65

1. PLACE OF DEATH:

(a) County Lawrence  
(b) City or town Aurora  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
38 West Pleasant St  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether years, months or days)  
In this community Fifty One Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lawrence  
(c) City or town Aurora  
(If outside city or town limits, write "RURAL")  
(d) Street No. 38 West Pleasant St.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

3. (a) PRINT FULL NAME William H Scott  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 300

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month November day 27 year 1939 hour Two minute Thirty

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Millie Scott 6. (c) Age of husband or wife if alive 68 years  
7. Birth date of deceased April 25- 1863  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from July 10-36 to Nov 27, 1939, that I last saw him alive on Nov 27, 1939, and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
76 7 2 hr. min.

Immediate cause of death Arterio-sclerosis Duration 20 or 4 years

9. Birthplace Andrew County Missouri  
(City, town, or county) (State or foreign country)

Due to Senile degeneration  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) 97

10. Usual occupation Groceryman

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

11. Industry or business Owner Of Grocery Store

MOTHER FATHER  
12. Name Robert Marion Scott  
13. Birthplace Kentucky  
(City, town, or county) (State or foreign country)  
14. Maiden name Sarah A Scott  
15. Birthplace Kentucky  
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? (City or town) (County) (State) \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

16. (a) Informant's own signature J. H. King & Scott  
(b) Address 38 W, Pleasant Aurora Mo.  
17. (a) Burial (b) Date thereof Nov. 29/39  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Aurora Mo.

While at work? (Specify type of place) \_\_\_\_\_  
(e) Means of injury \_\_\_\_\_

18. (a) Signature of funeral director J. H. King  
(b) Address Aurora Mo.  
19. (a) 12/1/39 (b) R. D. Cowan, M.D.  
(Date received local registrar) (Registrar's signature)

23. Signature W. H. Smith (M. D. or other) \_\_\_\_\_  
Address 10 W. Pleasant Aurora Date signed 11/27/39

SMW

**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

*Herman M. Purdy*

Licensed Embalmer No. *3072*

P. O. Address *Across the*

**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.**