

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

**40386**  
Do not use this space.

**1. PLACE OF DEATH**

(a) County NEWTON Registration District No. 611  
 (b) Township LIVEMILE Primary Registration District No. 6258 Registered No. \_\_\_\_\_  
 (c) City GENECA (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
 (e) Length of residence in city or town where death occurred 21 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

**2. PRINT FULL NAME**

EUELL NUMA SCOTT  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 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 FLORENCE SCOTT  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) JULY 15 1889  
 7. AGE YEARS 50 MONTHS 3 DAYS 19 If LESS than 1 day, ..... hrs. or ..... min.  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. LOF MINER  
 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) JUNE 1938 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) DADECO Mo. C

FATHER 13. NAME GRANVILLE SCOTT

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo. C

MOTHER 15. MAIDEN NAME SUSAN SMITH

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) DADECO Mo

17. INFORMANT (ADDRESS) Florence Scott Geneca RT 2

18. BURIAL, CREMATION, OR REMOVAL PLACE Ozark Memorial DATE Nov 7 1939

19. FUNERAL DIRECTOR (ADDRESS) Josephine, Mo

20. FILED Nov 10 1939 Therese Spartin Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 4 1939

22. I HEREBY CERTIFY, That I attended deceased from OCT 1 1939 to Nov 4 1939. I last saw him alive on Nov 4 1939. Death is said to have occurred on the date stated above, at 7 P. m.  
 The principal cause of death and related causes of importance were as follows:

Pulmonary Tuberculosis  
 Date of onset 1936  
 Other contributory causes of importance: 73'

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) J. N. Gray, M. D.  
 (Address) Josephine, 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 1239-2408

Date Filed DEC 4 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, .....

J. J. Anderson ....., or by .....

Registered Apprentice No. ...., working under my personal supervision.

Signed J. J. Anderson .....

Licensed Embalmer No. 2142

P. O. Address Joplin, Mo

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.

RECEIVED DISTRICT HEALTH OFFICER NO. 6

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

40386  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Newton Registration District No. 611  
 (b) Township Five mile Primary Registration District No. 6258 Registered No. \_\_\_\_\_  
 (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 Euell Norma death  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
50 3 19

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) unknown

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 1/16 1940 male franklin Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 4 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

Other contributory causes of importance:

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) J. M. Gentry, M. D.

(Address) Jefferson & No

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.

