

JAN 16 1940

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

43873  
Do not use this space.

1. PLACE OF DEATH

(a) County Lancaster Registration District No. 1024  
(b) Township Red Oak Primary Registration District No. 1631 Registered No. 5  
(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

Charles Foster Scott  
(a) Residence, No. Miller Ave 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 (write the word) M.

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) \_\_\_\_\_  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
73 7 5

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

FATHER 13. NAME Bennjamin Scott

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

MOTHER 15. MAIDEN NAME Josephine Foster

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

17. INFORMANT (ADDRESS) H. Herbert Scott Miller Ave

18. BURIAL, CREMATION, OR REMOVAL PLACE Red Oak DATE 12-21 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Morris - Lester Miller and

20. FILED 12-26 1939 St. Louis Local Registry

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-19 1939

22. I HEREBY CERTIFY, That I attended deceased from 12-14, 1939, to 12-19, 1939  
I last saw him alive on 12-18, 1939. Death is said to have occurred on the date stated above, at 11:20 a.m.  
The principal cause of death and related causes of importance were as follows:

Aedema of lung Date of onset \_\_\_\_\_

Other contributory causes of importance: asthma

Name of operation none 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? \_\_\_\_\_  
If so, specify \_\_\_\_\_  
(Signed) W. S. Bremer, M. D.  
(Address) Miller Ave

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 1010-243

Date Filed JAN 15 1940

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**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 con  
with the above constitutes grounds for revocation of license.)**

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

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

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

43879  
Do not use this space.

NOV 15 1939

1. PLACE OF DEATH

(a) County Laurens Registration District No. 1054  
 (b) Township Red Oak Primary Registration District No. 3031  
 (c) City \_\_\_\_\_ (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.

Registered No. 5-

2. PRINT FULL NAME Charles Foster Scott

(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, (write the word) m

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
73 7 5

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 12-26, 1939 Atta Wilson  
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-19, 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 W. S. Burney, M. D.  
 (Address) Miller Sub.

SUPPLEMENTARY

