

Registration District No. 399Primary Registration District No. 1002Registrar's No. 1781

## 1. PLACE OF DEATH:

(a) County Jackson  
 (b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
General Hospital #2  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 2-2-40-4-25-40  
(Specify whether  
 In this community Unknown  
years, months or days)

3. (a) PRINT FULL NAME Hazel Scott3. (b) If veteran,  
name war3. (c) Social Security  
No. None4. Sex Female5. Color or  
race Negro6. (a) Single, widowed, married,  
divorced Single

6. (b) Name of husband or wife

6. (c) Age of husband or wife if  
alive \_\_\_\_\_ years7. Birth date of deceased 5  
(Month)24  
(Day)1903  
(Year)

8. AGE:

Years

Months

Days

If less than one day

36111

hr.

min.

9. Birthplace Kansas City  
(City, town, or county)Kansas  
(State or foreign country)10. Usual occupation none

11. Industry or business

12. Name Henry Scott13. Birthplace Lexington  
(City, town, or county)Mo.  
(State or foreign country)14. Maiden name Nancy Williams15. Birthplace St. Louis  
(City, town, or county)Mo.  
(State or foreign country)16. (a) Informant's own signature Record Clerk(b) Address General Hospital #217. (a) Burial  
(Burial, cremation, or removal)(b) Date thereof 4-27-40  
(Month) (Day) (Year)(c) Place: burial or cremation Lincoln KC Mo18. (a) Signature of funeral director Thymus Greenstreet(b) Address 1819 E. 15th KC Mo19. (a) April 27, 1940  
(Date received local registrar)(b) M. M. Crowe  
(Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson  
 (c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 1614 Kansas Ave.  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 25  
 year 40 hour 7 minute 30 A. M.

21. I hereby certify that I attended the deceased from  
2-2- 1940, to 4-25 1940  
 that I last saw her alive on 4-25- 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death

Psoas Abscess of Right ThighDue to 26

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically

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?

While at work? \_\_\_\_\_ (Specify type of place)  
Means of injury 123. Signature [Signature] (M. D. or other)Address General Hospital #2 Date signed 4-26

**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

*Edw. J. ...*

Licensed Embalmer No. \_\_\_\_\_

*3836*

P. O. Address \_\_\_\_\_

*1819 E 15th Ave*

**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.**