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K21492

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

27765  
3399

Registration District No. 399 Primary Registration District No. 1002 State File No. Registrar's No.

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Kansas City  
(c) Name of hospital or institution:  
2013 Monroe Avenue  
(d) Length of stay: In hospital or institution 2  
In this community Life years, months or days (Specify whether)

3. (a) PRINT FULL NAME Mr. Joseph Beach Scovill  
(b) If veteran, name war None (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Mrs. Ida May Scovill 6. (c) Age of husband or wife if alive 73 years  
7. Birth date of deceased December 28 1864  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
75 8 0 hr. min.

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

10. Usual occupation Retired

11. Industry or business -----

MOTHER FATHER { 12. Name William Scovill  
13. Birthplace Michigan  
14. Maiden name Elizabeth Gear  
15. Birthplace Kentucky  
(City, town, or county) (State or foreign country)

16. (a) Informant Ida May Scovill  
(b) Address 2013 Monroe Avenue

17. (a) Burial (b) Date thereof Aug. 30, 1940  
(c) Place: burial or cremation Maple Hill Cemetery, Kansas City, Kansas

18. (a) Signature of funeral director W. H. Newcomb Lane  
(b) Address Kansas City, Missouri

19. (a) Aug. 29, 1940 (b) Mo. No. 100000  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(d) Street No. 2013 Montgall Avenue  
(e) If foreign born, how long in U. S. A.?

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month August day 28th  
year 1940 hour 5 minute 10 A. M.  
21. I hereby certify that I attended the deceased from August 20  
1940, to Date of Death, 1940,  
that I last saw him alive on August 28, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death hemorrhage (hemiplegic)  
Due to cerebrovascular accident  
Duration 2 yrs.

Other conditions General debility  
Major findings: Of operations -----  
Of autopsy -----

PHYSICIAN 51  
Underline the cause to which death should be charged statistically.

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? -----  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury !  
23. Signature W. H. Wyatt (M. D. or other)  
Address 3850 Prospect Date signed 8-28-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

3:30-7

**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 George M. Collier

Licensed Embalmer No. 3839

P. O. Address H. C. 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.**