

Registration District No. 395

Primary Registration District No. 5551A

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Blue Springs Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: In a bar. Mrs. [unclear]
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2
(Specify whether
In this community 50 yrs
years, months or days)

3. (a) PRINT FULL NAME Wm Scarborough

3. (b) If veteran, name war No
3. (c) Social Security No

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife Lora 6. (c) Age of husband or wife if alive years

7. Birth date of deceased Nov 8 18 58
(Month) (Day) (Year)

8. AGE: Years 81 23 Months 9 Days 14 If less than one day hr. min.

9. Birthplace Stamping Ground Ky
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer Ret

11. Industry or business

12. Name Henry - Ky

13. Birthplace Staked Ky
(City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace Ky
(City, town, or county) (State or foreign country)

16. (a) Informant Harrison Scarborough

(b) Address Blue Springs Mo

17. (a) Burial (b) Date thereof Aug 24-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Blue Springs Mo

18. (a) Signature of funeral director ROBERT [unclear]
(b) Address Blue Springs

19. (a) Aug 26 - 1940 (b) Mrs Thelma Perkins
(Date registered local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town Blue Springs Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 3 1/2 mi N Blue Springs Mo
(If rural, give location)
(e) If foreign born, how long in U. S. A.?

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 22nd
year 1940 hour 5:00 minute a. M.

21. I hereby certify that I attended the deceased from Jan 1, 1940
to Aug 22, 1940
that I last saw him alive on Aug 20, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death: Senile Pneumonia 4 days
Due to Chr. Nephritis 5 yrs
Due to Myocardial degen. 5 yrs
Other conditions: arterio-sclerosis
(Include pregnancy within 3 months of death)

Major findings: Of operations None
Of autopsy None

Duration

PHYSICIAN

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?
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
981
While at work? (Specify type of place) (e) Means of injury

23. Signature J. H. [unclear] (M. D. or other)
Address Blue Springs Mo Date signed 8-26-40

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

FILED SEP 16 1940

MOTHER FATHER

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 comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **28746**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **395**

Primary Registration District No. **5-5-27A**

Registrar's No.

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

1. PLACE OF DEATH:

(a) County **Jackson**
(b) ~~City or town~~ **Seniava**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME **Wm Seabrough**

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex **m** 5. Color or face **w** 6. (a) Single, widowed, married, divorced **wid**

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year

7. Birth date of deceased **Nov 8 1858**
(Month) (Day) (Year)

8. AGE: Years **81 82** Months **9** Days **14**
If less than one day hr..... min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....
(City, town, or county) (State or foreign country)

14. Maiden name.....

15. Birthplace.....
(City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof.....
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) **10/22/40** (b) **Mrs. Thomas Portwood**
(Date received local registrar) (Registrar's name)
(by Dr. J. C. Harvey)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **Aug** day **22**
year **1940** hour..... minute..... M.

21. I hereby certify that I attended the deceased from.....
19..... to..... 19.....
that I last saw h..... alive on..... 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death.....

Due to.....

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy.....

Duration

PHYSICIAN

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?.....
(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)
(e) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

SUPPLEMENTAL ONLY

