

Registration District No. **547**

Primary Registration District No. **3029**

Registrar's No. **290**

1. PLACE OF DEATH:

(a) County **Marion**
 (b) City or town **Hannibal**
 (c) Name of hospital or institution: **105 S. Levering St. Residence**
 (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 years, months or days) **1**

3. (a) PRINT FULL NAME **Mrs. Alta Biggs Scott**

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

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Claude C. Scott** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **February 3, 1896**
 (Month) (Day) (Year)

8. AGE: Years **44** Months **6** Days **29** If less than one day hr. _____ min. _____

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

10. Usual occupation **Housewife**

11. Industry or business

MOTHER { 12. Name **William S. Strother**
 13. Birthplace **Louisiana Missouri**
 (City, town, or county) (State or foreign country)
 FATHER { 14. Maiden name **Fanny Snodwell**
 15. Birthplace **Frankford Missouri**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Claude C. Scott**

(b) Address **105 South Levering**

17. (a) **Burial** (b) Date thereof **10/4/40**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Grandview Burial Park**

18. (a) Signature of funeral director **W. J. Fisher**

(b) Address **902 Broadway Hannibal Missouri**

19. (a) **10-7-1940** (b) **W. J. Fisher**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Marion**

(c) City or town **Hannibal**
 (If outside city or town limits, write "RURAL")

(d) Street No. **105 South Levering**
 (If rural, give location)

(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **2**
 year **1940** hour **2:00** minute _____ P. M.

21. I hereby certify that I attended the deceased from **July 1st**, 1940, to **Oct. 21**, 1940
 that I last saw her alive on **Oct. 2**, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death **Strangulation**

Due to **Metastatic Carcinoma of the esophagus and trachea**

Due to **Carcinoma of the left breast and left lung**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations: _____

Of autopsy _____

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 **E. A. Porter M.D.** (M.D. or other) _____

Address **412 Center St. Hannibal, Mo.** Date signed **10-5-40**

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

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

4
15

NOV 20 1940

5
MAY 5 1943

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

Joseph J. Marsh

Licensed Embalmer No. 3932

P. O. Address Hannibal Missouri

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **35-799**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **347**

Primary Registration District No. **3029**

Registrar's No. _____

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

1. PLACE OF DEATH:
 (a) County Marion
 (b) City or town Hannibal
(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)

3. (a) PRINT FULL NAME Mrs Alta Biggs Scott
 3. (b) If veteran, name war _____ (c) Social Security No. _____

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

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

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
44 6 29 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 _____ (City, town, or county) (State or foreign country)

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

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (Specify type of place)

(b) Address _____ (c) Means of injury _____

19. (a) _____ (b) _____ (Registrar's signature)

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.

20. DATE OF DEATH: Month Oct day 2
 year _____ 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 _____ and hour stated above.

Immediate cause of death Strangulation
metastasis carcinoma
of the esophagus
and trachea
carcinoma of the left
breast and left lung
 Duration _____

Other conditions possibly some metastasis
(include pregnancy within 3 months of death)
to liver and rt. lung and other

Major findings: left breast was
removed 14 months prior to
death (primary)
 Of autopsy no autopsy

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) 50

(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?

23. Signature E. A. Porter, B.S.P.H.

Address 412 Center St Date signed _____

Hannibal, Mo. 12/15/40

SUPPLEMENTAL

