

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **37637**
Registrar's No. **4235**

Registration District No. **399**

Primary Registration District No. **1002**

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:
K. C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **13 days** (Specify whether years, months or days)
In this community **56 years**

3. (a) PRINT FULL NAME **S. ROBERT SCOTT**

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

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Elizabeth Horn** 6. (c) Age of husband or wife if alive **dec.** years
7. Birth date of deceased **March 11th, 1853**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
87 **7** **24** hr. min.

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

10. Usual occupation **Retired Druggist**

11. Industry or business **Drug**

MOTHER { 12. Name **Unknown**
13. Birthplace **Unknown**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Nina Horn**

(b) Address **20 Westport Ave., Kansas City, Mo.**

17. (a) **Burial** (b) Date thereof **11-7-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Stine & McClure**

(b) Address **3235 Gillham Plaza, K. C., Mo.**

19. (a) **11-6-40** (b) **M. M. Clouse**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **20 Westport Road**
(If rural, give location)
(e) If foreign born, how long in U. S. A. **no.** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **5th**
year **1940** hour **6** minute **10 P.** M.

21. I hereby certify that I attended the deceased from **10-23-40**, to **11-5-40**, 19....;

that I last saw him alive on **11-5-40**, 19....;

and that death occurred on the date and hour stated above.

Immediate cause of death **Hypostatic bronchopneumonia**

Due to **Senile dementia**

Due to **107a**

Other conditions **None**
(Include pregnancy within 3 months of death)

Major findings: Of operations _____ Of autopsy **None**

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? _____

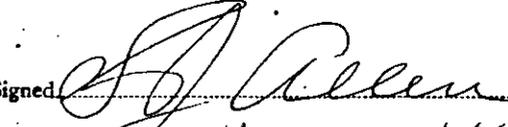
While at work _____ (Specify type of place) (c) Means of injury _____
23. Signature **Mrs. Nina Horn** (M. D. or other) _____
Address **Med. Dir. K. C. Gen. Hospital, KC Mo.** Date signed _____

RECEIVED DEC 17 1940

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. 1413 -

P. O. Address B. E. 170

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.