

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

N. E.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Registration District No. 230

Primary Registration District No. 4140

State File No. _____

Registrar's No. 66

1. PLACE OF DEATH:

(a) County Crawford

(b) City or town Cuba
(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

3. (a) PRINT FULL NAME Jennie Scott

8. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Louis C. Scott

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

7. Birth date of deceased Nov. 18th 1862
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>77</u>	<u>0</u>	<u>13</u>	hr. _____ min. _____

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

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER

12. Name John Hiram Lewis

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

14. Maiden name Marjorie Esthine

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

16. (a) Informant's own signature Florence Morrison

(b) Address Cuba, Mo.

17. (a) Burial
(Burial, cremation, or removal)

(b) Date thereof 12-3-1939
(Month) (Day) (Year)

(c) Place: burial or cremation Hibler Cym. Steubille

18. (a) Signature of funeral director J. G. Vallan

(b) Address Cuba, Mo.

19. (a) Dec. 2, 1939 (b) J. G. Vallan
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Crawford

(c) City or town Cuba
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 1st
year 1939 hour 5 minute 30 A. M.

21. I hereby certify that I attended the deceased from Jan 3, 1937 to Dec. 1, 1939
that I last saw her alive on Dec. 1, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Valvular Heart Disease Duration 5 yrs

Due to _____

Due to _____

Other conditions _____
(Includes pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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 Gustave G. A. Herzog (M. D. or other) _____
Address Cuba, Mo. Date signed 12/2/39

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.....

Jas. H. Hallaw

Licensed Embalmer No. *3643*

P. O. Address..... *Cuba, 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.