No. 2
11-10-39
5-17-39
P I X21492

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FEB 18 1941

Registration District No. 688

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3867

Primary Registration District No. 4412

Registrar's No. 3

1. PLACE OF DEATH:
(a) County: Pike
(b) City or town: Frankford (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: 21 Years (Specify whether years, months or days) In this community:

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Pike 812
(c) City or town: Frankford 0 (If outside city or town limits, write "RURAL") 0
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME: Clayton Scott
3. (b) If veteran, name war:
3. (c) Social Security No.:
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Single 0
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: Oct (Month) 26 (Day) 1903 (Year)
8. AGE: Years 37 38 | Months 3 | Days 5 | If less than one day: hr. min.
9. Birthplace: Ralls County (City, town, or county) Missouri 0 (State or foreign country)
10. Usual occupation: Farmer
11. Industry or business:
FATHER 12. Name: Jesse Scott
FATHER 13. Birthplace: (City, town, or county) Kentucky / (State or foreign country)
MOTHER 14. Maiden name: Nellie Woods
MOTHER 15. Birthplace: RallsCounty (City, town, or county) Missouri (State or foreign country)
16. (a) Informant: Glenn Scott
(b) Address: New London Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb 3 1941 (Month) (Day) (Year)
(c) Place: burial or cremation: New London Missouri
18. (a) Signature of funeral director: Fulkerson
(b) Address: Frankford Missouri
19. (a) Feb. 7-41 (Date received local registrar) (b) Mattie Unsell (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 31 year 1941 hour 7 minute 30 P.M.
21. I hereby certify that I attended the deceased from Jan. 15 1941 to Jan. 31 1941 that I last saw alive on Jan. 31 1941 and that death occurred on the date and hour stated above.

Immediate cause of death: Interstitial Pneumonia

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? (Specify type of place)
While at work? (e) Means of injury:
23. Signature: O. W. Fridgerson (M. D. or other)
*Address: Frankford Mo Date signed 2/8/41

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 2-41-350
Date Filed FEB 15 1941

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 Jone Fields Megow

Licensed Embalmer No. 4093

P. O. Address Frankford, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

No. 2B
2-21-40
I X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 3867

Registration District No. 688 Primary Registration District No. 4412 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Pike

(b) City or town Frankford (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 years, months or days)

In this community

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 Crayton Scott

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Oct 26 1903 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day hr. min.
37 ~~38~~	3	5	

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) Mattie Lusell (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Jan day 31 year 1941 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.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include 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? (Specify type of place)

While at work? (e) Means of injury

23. Signature O. N. Snodgrass (M. D. or other)

Address Frankford Date signed