

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 14

Registration District No. 827 Primary Registration District No. 4500

1. PLACE OF DEATH: Shilly, Missouri
(a) County: Shilly
(b) City or town: Shilly
(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 _____
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED: 1602
(a) State: Missouri (b) County: Shilly
(c) City or town: Shilly
(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: Empress Dudley Scott
(b) If veteran, name war: _____
(c) Social Security No.: yrs.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month: April day: 25, 1941
year: 1941 hour: 2 A.M. minute: M.

4. Sex: male
5. Color or race: m
6. (a) Single, widowed, married, divorced: 1
(b) Name of husband or wife: Melissa D. Lewis
(c) Age of husband or wife if alive: _____ years
7. Birth date of deceased: May 4th 1889
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Feb. 1939 to April 25, 1941, and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	43	11	21	hr. min.

Immediate cause of death: Pancreas
Due to: Hemiplegia
Due to: Hypertension
Other conditions: _____
(Include pregnancy within 3 months of death)

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

PHYSICIAN
Major findings: _____
Of operations: _____
Of autopsy: _____
Underline the cause to which death should be charged statistically.

10. Usual occupation: Farmer
11. Industry or business: _____
12. Name: James Arthur Scott
13. Birthplace: Ill (City, town, or county) Ill (State or foreign country)
14. Maiden name: Sarah August
15. Birthplace: Ill (City, town, or county) Ill (State or foreign country)

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? _____

16. (a) Informant: Paula Huett
(b) Address: Claremo Mo
17. (a) Burial (b) Date thereof: 5-27-1941
(Month) (Day) (Year)
(c) Place: burial or cremation: Burial

23. Signature: Frank C. Roy (M. D. or other) _____
Address: Claremo Mo Date signed: 5/5/41

18. (a) Signature of funeral director: _____
(b) Address: _____
19. (a) May 8-1941 (b) Roy Hamilton
(Date received local registrar) (Registrar's signature)

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

83A

E. BERNY

RECEIVED

District Health Officer No. 10

District File Number 5-41-921

Date Filed MAY 14 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.....

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, above space should be left blank.

Registration District No. 827

Primary Registration District No. 4500

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Shelby

(b) City or town Clarence
(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 _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Amrose Dudley 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 m

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ year _____ month _____ day _____

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

8. AGE:	Years	Months	Days	If less than one day
	<u>83</u>	<u>11</u>	<u>21</u>	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) _____ (b) _____
(Date received local registrar) (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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month apr day 25 year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Langrene

Due to Hemiplegia due to cerebral hemorrhage

Due to Hypertension

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 Frank Roy (M. D. or other) _____

Address Clarence Date signed 6-27-41

SUPPLEMENTAL

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

MOTHER FATHER

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

