

DEC 22 1941 399
Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 4117

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:
TRINITY HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Washington Township, N.W. Hickman Mills
(If rural, give location)
(e) If foreign born, how long in U. S. A? years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11-4-41 day _____ year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from 10-29-41 to _____, 19____, to _____, 19____; that I last saw him alive on 11-4-41, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive
Decomposed
Duration _____

Due to Fract. Hip

Due to _____

Other conditions Art. Sclerosis
(Include pregnancy within 3 months of death)

Hypertensive c-v. disease
Major findings: _____
Of operations _____

Of autopsy Sound
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 11/4/41

(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 0

23. Signature Robert M. Myers (M. D. or other) M.D.

Address 1025 Quaila Bldg Date signed 11-5-41

3. (a) PRINT FULL NAME WILLIAM C. 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 MARRIED

6. (b) Name of husband or wife MAYME SCOTT 6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased JUNE 20 1866
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>75</u>	<u>4</u>	<u>4</u>	br. _____ min.

9. Birthplace HICKMAN MILLS MO. 10
(City, town, or county) (State or foreign country)

10. Usual occupation RETIRED FARMER

11. Industry or business _____

MOTHER FATHER { 12. Name John M. Scott

13. Birthplace ANN ARBOR, MICHIGAN
(City, town, or county) (State or foreign country)

14. Maiden name LAURICA COLLIER

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

16. (a) Informant's own signature Harry Scott

(b) Address Hickman Mills, Mo.

17. (a) Burial (b) Date thereof Nov. 6, 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park, K.C., Mo.

18. (a) Signature of funeral director E. H. George Jones

(b) Address Grandview

19. (a) 11-5-41 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

5/1

N. B.—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. U.S. GOVERNMENT PRINTING OFFICE: 1938

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. *3645*

P. O. Address *Grandview, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No.

Primary Registration District No.

Registrar's No. **4117**

1. PLACE OF DEATH:

(a) County
 (b) City or town
 (c) Name of hospital or institution:
Trinity Hospital
 (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 William C. Scott

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

4. Sex 5. Color or race 6. (a) Single, widowed, married, divorced
 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
75 4 4 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. (Month) (Day) (Year)

(c) Place: burial or cremation.

18. (a) Signature of funeral director.

(b) Address. 127 30/41 M. M. Brown

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
 (c) City or town Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. Lidsman hills R.F.D.
 (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH. Month November day 4
 year 1941 hour minute M.

21. I hereby certify that I attended the deceased from 10-29-41
 19..... to 11-4-41, 19.....
 that I last saw him alive on 11-4-41, 19.....
 and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic pneumonia

Due to Frac. hip

Due to 1860
14

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) Accident

(b) Date of occurrence 10-29-41

(c) Where did injury occur? Home - Lidsman hills
 (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home

While at work (Specify type of place) (e) Means of injury Fall

Signature Robert M. Myers (M. D. or other) M.D.

Address 1025 Duval Date signed 12-23-41

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

SUPPLEMENTAL

S-37323

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, fact should be so stated above.