

FILED AUG 11 1942

Registration District No. 174

Primary Registration District No. 5644

1. PLACE OF DEATH:

(a) County Lafayette

(b) City or town Country Farm

(c) Name of hospital or institution: 1 destination w/p
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 1/2 yrs
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette

(c) City or town Lower Lafayette
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME HARRISON 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

6. (b) Name of husband or wife.

6. (c) Age of husband or wife if alive 25 years (Month) (Day) (Year)

7. Birth date of deceased July 25 1868
(Month) (Day) (Year)

8. AGE: Years 74 Months 11 Days 22 If less than one day hr. min.

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

10. Usual occupation Farmer

MOTHER FATHER

11. Industry or business.

12. Name Harrison Scott

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

14. Maiden name Jane Scott

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

16. (a) Informant Jeze Martin, Sup. Co. Farmer

(b) Address Washington, Mo.

17. (a) Burial (b) Date thereof July 8, 1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation County Farm, Laf. Co.

18. (a) Signature of funeral director W. Schuber

(b) Address Washington, Mo.

19. (a) 7-18-42 (b) Mrs. Fred Schuber
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 17 year 1942 hour 4 minute PM

21. I hereby certify that I attended the deceased from March, 1941 19 July 16 19 42
and that death occurred on the date and hour stated above.

that I last saw h alive on July 16 19 42
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Rt.

Due to.

Due to.

Other conditions 830
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: Of operations.

Of autopsy.

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 0

23. Signature C. J. Jesseel (M. D. Sever)
Address Highwayville, Mo. Date signed 7/17/42

54
0
0
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 8

District File Number _____

Date Filed 8-10-42

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. 2983

P. O. Address Livingston Ave

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.