

Registration District No. **199**

Primary Registration District No. **5721**

Registrar's No. **8**

1. PLACE OF DEATH: **Macon**
(a) County **Macon**
(b) City or town **Dallas Rural**
(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 **Mo** (b) County **Macon**
(c) City or town **Dallas Rural**
(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 **0**

3. (a) PRINT FULL NAME **JAMES W. SCOBEE**
3. (b) If veteran, **✓** name war **✓**
3. (c) Social Security No. **✓**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Sept** day **28**
year **1942** hour **4** minute **0** P. M.

4. Sex **MALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **WIDOWER**
6. (b) Name of husband or wife **SARAH SCOBEE** 6. (c) Age of husband or wife if alive **16** years (Month) (Day) (Year)
7. Birth date of deceased **OCTOBER 1847** (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **July 28**, 1942 to **Sept 27**, 1942
that I last saw him alive on **Sept 27**, 1942
and that death occurred on the date and hour stated above.

8. AGE: Years **94** Months **11** Days **12** If less than one day hr. min.

Immediate cause of death **Acute Myocardial Infarction**
Duration **4 days**

9. Birthplace **SHELBY CO KENTUCKY** (City, town, or county) (State or foreign country)
10. Usual occupation **FARMER**

Due to **Enlarged Prostate which caused retention of urine**
Due to **of urine**

11. Industry or business
12. Name **STEVEN SCOBEE**
13. Birthplace **Shelby co Kentucky** (City, town, or county) (State or foreign country)
14. Maiden name **MARY J. DAVIS**
15. Birthplace **Shelby co Kentucky** (City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death)
Major findings: **E 137a**
Of autopsy **no**

16. (a) Informant **Argello Seader**
(b) Address **Dallas Mo**
17. (a) **Burial** (b) Date thereof **9-30-42** (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Charity Church Am**
18. (a) Signature of funeral director **H. Edwards**
(b) Address **7311 Mo**
19. (a) **9-30-1942** (b) **H. J. Allen** (Date received local registrar) (Registrar's signature)

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 **Howard** (M. D. or other)
Address **New Orleans La** Date signed **3/28/42**

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

61
0
0

RECEIVED

Health Officer No. 10

File Number 10-42-1826

~~DATE~~ OCT - 7 1942

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

J. E. Edwards

Licensed Embalmer No.

1961

P. O. Address

Beverly, 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, fact should be so stated above.