

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11176

FILED APR 7 1943

Registration District No. 157

Primary Registration District No. 6000.

State File No.

Registrar's No.

1. PLACE OF DEATH:

(a) County Ralls
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
5 1/2 miles north of Laddonia, Mo
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.
In this community 60 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME FRED SCOTFIELD

3. (b) If veteran, name war no 3. (c) Social Security No none

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Ara Scofield 6. (c) Age of husband or wife if alive 64 years
7. Birth date of deceased Dec. 17 1870
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
72 3 8 hr. min.

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

10. Usual occupation Farming

11. Industry or business Farm
12. Name Samuel Scofield
13. Birthplace New York
14. Maiden name Julia Scofield
15. Birthplace New York
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Fred Scofield
(b) Address Laddonia, Mo

17. (a) Burial (b) Date thereof March 27 43
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Vandalia, Mo

18. (a) Signature of funeral director H. S. Grainger
(b) Address Laddonia, Mo

19. (a) Mar. 28 43 (b) Mrs. Earl Burkman
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Ralls, Co.
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 5 1/2 miles north of Laddonia
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 25 year 1943 hour 2 minute 00 M.

21. I hereby certify that I viewed the deceased from body 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 Cornary Thrombosis

Due to
Due to

Other conditions (Include pregnancy within 3 months of death) g & a

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 H. E. Burkman (M.D. or other) Cooper
Address New London, Mo Date signed 3/28/43

RECEIVED

District Health Officer No. 10

District File Number 43-630

Date Filed APR 6 1943

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.....

H. G. Grainger....., Registered Apprentice No.....
working under my personal supervision.

Signed H. G. Grainger.....

Licensed Embalmer No. 1297

P. O. Address Ladonia, 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.