S. No. 2
M—9-4-41
5-17-39
PI X2

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

13406

State File No.

FILED MAY 3 1943

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1663

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

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: Kansas City T.B. Hosp. O
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days (Specify whether
In this community 2 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Pettis 86
(c) City or town Sedalia 4
(If outside city or town limits, write "RURAL")
(d) Street No. 416 North Ohio
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country /

3. (a) PRINT FULL NAME Charles Clayton Scott
3. (b) If veteran, name war no
3. (c) Social Security No. 491-07-7620

4. Sex M
5. Color or race ed
6. (a) Single, widowed, married, divorced Widowed 2
6. (b) Name of husband or wife unknown
6. (c) Age of husband or wife if alive years
7. Birth date of deceased 1 (Month) 23 (Day) 1892 (Year)

8. AGE: Years 51 Months 1 Days 29 If less than one day hr. min.

9. Birthplace Dresden (City, town, or county) Mo O (State or foreign country)
10. Usual occupation laborer
11. Industry or business
FATHER
12. Name James Scott
13. Birthplace Dresden (City, town, or county) Mo O (State or foreign country)
MOTHER
14. Maiden name Jannie Lee
15. Birthplace Dresden (City, town, or county) Mo O (State or foreign country)
16. (a) Informant Records K.C.T.B. Hosp
(b) Address K.C. Mo.
17. (a) Sedalia (Burial, cremation, or removal) (b) Date thereof 4-10-1943 (Month) (Day) (Year)
(c) Place: burial or cremation Dresden Mo
18. (a) Signature of funeral director F. D. Ferguson
(b) Address Sedalia, Mo.
19. (a) 4/7/43 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 22 year 1943 hour 11 minute 35 A.M.
21. I hereby certify that I attended the deceased from 3-20-43, 19, to 3-22, 1943 that I last saw him alive on 11:35 AM 3-22-43 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pulmonary Tuberculosis	1 yr.
Due to 13 B	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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? (Specify type of place)
While at work? (e) Means of injury O
23. Signature Matthew J. Noon (M. D. or other)
Address K.C. T.B. Hosp Date signed 3/22/43

361

(Licensed Embalmer's Statement on Reverse Side)

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. 2192

P. O. Address. Sedalia

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.