

Registration District No. **286**

Primary Registration District No. **4424**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Polk**
(b) City or town **HUMANSVILLE**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **48 YEARS**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **Polk**
(c) City or town **HUMANSVILLE**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **ARMINTA D. Scott**

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

4. Sex **FEMALE** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Edgar C. Scott** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Oct. 17 1856**
(Month) (Day) (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-----------|----------|-----------|----------------------|
| | 86 | 9 | 14 | hr. _____ min. _____ |

9. Birthplace **HANCOCK Co. Ohio**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business **Self**

MOTHER FATHER

12. Name **SAMUEL Wright**

13. Birthplace **UNKNOWN Ohio**
(City, town, or county) (State or foreign country)

14. Maiden name **TABIGNA McMAHAN**

15. Birthplace **UNKNOWN Ohio**
(City, town, or county) (State or foreign country)

16. (a) Informant **W. S. Scott**

(b) Address **Humansville Mo**

17. (a) **BURIAL** (b) Date thereof **AUG. 3-1943**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **HUMANSVILLE CEMETERY**

18. (a) Signature of funeral director **E. Humm**
(b) Address **Humansville Mo**

19. (a) **AUG 4-43** (b) **Ora M. Rich**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug.** day **1st**
year **1943** hour **10** minute **15** P. M.

21. I hereby certify that I attended the deceased from **July 27 1943** to **Aug 1st 1943**
that I last saw her alive on **Aug 1st 1943**
and that death occurred on the date and hour stated above.

Immediate cause of death **Lactated bowels probably due to adhesion from an old rupture.**
Due to _____
Due to _____

Duration **5 days**

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?

While at work? _____ (Specify type of place)
(e) Means of injury **D**

23. Signature **Roscoe C. Neuns** (M. D. or other) **M.D.**
Address **Humansville Mo** Date signed **8-2-43**

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

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12 12
12 12

RECEIVED

District Health Officer No. 7

District File Number

Date Filed

8-43-408
9-7-43

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.....

by me
....., Registered Apprentice No.....

working under my personal supervision.

Signed

E. H. Pinner

Licensed Embalmer No.

4282

P. O. Address

Hamansville, 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.