

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31525

State File No.

LED OCT 6 1948
Registration District No. 2-

Primary Registration District No. 3017

Registrar's No. 114

1. PLACE OF DEATH:

(a) County **COOPER**

(b) City or town **BOONVILLE**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
ST. JOSEPH'S HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **3 MONTHS**
(Specify whether years, months or days)

In this community **1 YEAR**

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **COOPER** **027**

(c) City or town **BOONVILLE**
(If outside city or town limits, write "RURAL") **2**

(d) Street No. **7th & MORGAN STREETS**
(If rural, give location)

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

3. (a) PRINT FULL NAME **MRS CATHERINE SCOTT**

3. (b) If veteran, name war **NONE**

3. (c) Social Security No. **NONE**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **10**
year **1948** hour **6⁰⁰** minute **0** M.

4. Sex **FEMALE** 5. Color or race **WHITE**

6. (a) Single, widowed, married, divorced **WIDOWED**

6. (b) Name of husband or wife **EDWARD SCOTT**

6. (c) Age of husband or wife if alive **DECEASED**

7. Birth date of deceased **AUGUST 30 1874**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Sept 7 - 11 1948**
to **Sept 10 1948**
that I last saw her alive on **Sept 8 1948**
and that death occurred on the date and hour stated above.

Immediate cause of death **asc. car. lungs & bowels**

8. AGE: Years Months Days If less than one day

69 0 11 hr. min.

Due to **chronic ulcer stomach & gas**

9. Birthplace **COOPER COUNTY MISSOURI**
(City, town, or county) (State or foreign country)

Due to

Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation **HOUSEWIFE**

11. Industry or business **HOME**

PHYSICIAN

MOTHER FATHER { 12. Name **WILLIAM DWYER**

13. Birthplace **TIPPERARY IRELAND**
(City, town, or county) (State or foreign country)

14. Maiden name **MARY MEEHAN**

15. Birthplace **TIPPERARY IRELAND**
(City, town, or county) (State or foreign country)

Major findings: Of operations **No ops**

Of autopsy **See above**

Underline the cause to which death should be charged statistically.

16. (a) Informant **MRS R.E. RHOADES**

(b) Address **BOONVILLE, MO.**

17. (a) **BURIAL** (b) Date thereof **9/13/48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **SS PETER & PAUL'S CEM.**

18. (a) Signature of funeral director **STEGNER & KOENIG**

(b) Address **BOONVILLE, MO.**

19. (a) **Sept. 13-48** (b) **Dr Chas. Swap**
(Date received local registrar) (Registrar's signature)

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 **W.L. Evans** (M. D. or other)

Address

Date signed

108 * (Licensed Embalmer's Statement on Reverse Side)

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

27
1
2

RECEIVED

District Health Officer

Date Filed 10-1-43

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *James W. Segner*.....
Licensed Embalmer No. *3780*.....
P. O. Address *Boonville, 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.

Registration District No. 82 Primary Registration District No. 3017 Registrar's No. 114

1. PLACE OF DEATH:
(a) County Cooper
(b) City or town Boonville
(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
In this community years, months or days) (Specify whether

3. (a) PRINT FULL NAME Catherine Scott
3. (b) If veteran, name war 3. (c) Social Security No.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive years
7. Birth date of deceased Aug 30 1884
(Month) (Day) (Year)

8. AGE: Years 69 Months 0 Days 0 In less than one day min.
9. Birthplace MO.
(City, town, or county) (State or foreign country)

10. Usual occupation
11. Industry or business
MOTHER { 12. Name
FATHER { 13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (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

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept day 10
year 1930 hour 11 minute 0 M.
21. I hereby certify that I attended the deceased from
that I last saw him alive on 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death abscess lung Duration
Tubercular

Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
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) (c) Means of injury

23. Signature R. L. Evans (M. D. or other)
Address Boonville MO Date signed

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

SUPPLEMENTARY

PHYSICIAN
Underline the cause to which death should be charged statistically.

31525