

DEPARTMENT OF COMMERCE

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED JAN 21 1944

Registration District No. 374

Primary Registration District No. 62734

Registrar's No.

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

13
8

1. PLACE OF DEATH:

(a) County North

(b) City or town Grant City, Mo.
(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 1
(Specify whether Life)

In this community Life
years, months or days

3. (a) PRINT FULL NAME Lucy LaVesta Scadden

3. (b) If veteran, name war:

3. (c) Social Security No.:

4. Sex ♀

5. Color or race W

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

6. (b) Name of husband or wife Del Scadden

6. (c) Age of husband or wife if alive 82 years

7. Birth date of deceased Oct. 14 1866
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>77</u>	<u>1</u>	<u>29</u>	hr. min.

9. Birthplace Grant City Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business:

12. Name Symoniah Hilford

13. Birthplace Mo
(City, town, or county) (State or foreign country)

14. Maiden name Melba Dand

15. Birthplace Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Virgil Scadden

(b) Address Grant City, Mo.

17. (a) Burial (b) Date thereof 12-15-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Grant City Cem.

18. (a) Signature of funeral director John C. Dumble

(b) Address Grant City, Mo.

19. (a) Jan 2, 1944 (b) Arlene Scadden
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County North

(c) City or town Grant City, Mo. 117
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 13
year 1943 hour 3 minute A. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him alive on 12-12, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 940

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 Bentley Neafis (M.D. or other) _____
Address Grant City Date signed 12-20-43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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..... *Arch C. Dingle*

Licensed Embalmer No. *3252*

P. O. Address. *Grant City 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.