

Registration District No. 275

Primary Registration District No. 3053

Registrar's No. 15

1. PLACE OF DEATH

(a) County Shelby
 (b) City or town Reese
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: McFarland Hospital
 (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) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Shelby
 (c) City or town Reese
 (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

Ralph Homer Scott

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex ma 5. Color or race white 6. (a) Single, widowed, married, divorced married

(b) Name of husband or wife Rose Scott 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Mar. 24 1911
 (Month) (Day) (Year)

8. AGE: Years 32 Months 10 Days 16 If less than one day _____ hr. _____ min.

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

10. Usual occupation laborer

11. Industry or business

12. Name Jahn P. Scott
 13. Birthplace Mo
 (City, town, or county) (State or foreign country)
 14. Maiden name Betty Layton
 15. Birthplace Mo
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Roger Williams
 (b) Address Reese Mo
 17. (a) Burial (b) Date thereof 2/13/44
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Reese Cem

18. (a) Signature of funeral director Roger Williams
 (b) Address Reese Mo

19. (a) 2/13/1944 (b) Roger Williams
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 10
 year 1944 hour 1:30 minute 0 M.

21. I hereby certify that I attended the deceased from Feb 8
1944 to Feb 10 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death Acute Gastritis and enteritis from food or drink
 Duration _____

Due to _____

Due to _____

Other conditions. (Include pregnancy within 3 months of death) 118'3

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 _____

23. Signature Roger Williams (M. D. or other) _____
 Address Reese Mo Date signed 2/11/44

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

21
2
2

MOTHER FATHER

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

Signed S. L. Hill
Licensed Embalmer No. 3397
P. O. Address Roller 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.