

No. 2  
A-2-43  
5-17-39  
X35697

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

27596

FILED SEP 8 1944  
Registration District No. 193

Primary Registration District No. 4154

State File No. \_\_\_\_\_  
Registrar's No. 49

1. PLACE OF DEATH

(a) County Madison  
(b) City or town Greenfield mo  
(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 \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Madison  
(c) City or town Greenfield  
(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 \_\_\_\_\_

3. (a) PRINT FULL NAME Emerson C. Scott

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

4. Sex M 5. Color or Race W 6. (a) Single, widowed, married, divorced, widowed  
6. (b) Name of husband or wife Mary R. Scott 6. (c) Age of husband or wife if alive 59 years  
7. Birth date of deceased Feb 24 1864  
(Month) (Day) (Year)

8. AGE: Years 80 Months 5 Days 28 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Greenfield mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

MOTHER { 12. Name Emerson C. Scott  
13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)  
14. Maiden name Mary R. Scott  
15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant Walter E. Scott  
(b) Address Greenfield mo  
17. (a) Burial (b) Date thereof 8/24/44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Greenfield cemetery

18. (a) Signature of funeral director Wm. D. Allison  
(b) Address Greenfield mo  
19. (a) 8/24/44 (b) Phyllis Lusk  
(Date received, local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 22  
year 44 hour 12 am minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from Aug 1 - 42  
19\_\_\_\_, to Aug 27 1944  
that I last saw him alive on Aug 28  
and that death occurred on the date and hour stated above.

Immediate cause of death apoplexy  
Duration \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions 83rd  
(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 \_\_\_\_\_  
23. Signature J. D. Cavan (M. D. or other) \_\_\_\_\_  
Address Greenfield mo Date signed 8-22-44

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

1082

RECEIVED

District Health Officer No. 6,

District File Number 944-996

Date Filed SFP 6 1944

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.....

W<sup>m</sup> R. Allison

Registered Apprentice No. 366

working under my personal supervision.

Signed R. L. Hauschild

Licensed Embalmer No. 3237

P. O. Address Lockwood 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.