

FILED AUG 22 1944

Registration District No. 140

Primary Registration District No. 3024

Registrar's No. 50

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

1. PLACE OF DEATH

(a) County Howard

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

(c) Name of hospital or institution:  
Mr. Lopez Convalescent Home  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community 9 weeks  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Howard

(c) City or town New Franklin  
(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 ANNIE ELIZABETH SCOTT

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 6  
year 1944 hour 12 minute 08 A.M.

21. I hereby certify that I attended the deceased from May 25, 1944, to July 5, 1944,  
that I last saw her alive on June 5, 1944,  
and that death occurred on the date and hour stated above.

Immediate cause of death: heart failure

Due to: Stroke Paralysis of right side which involve of all vital organs

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations: \_\_\_\_\_

Of autopsy: \_\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Divorced Widowed

6. (b) Name of husband or wife Adolphus H. Scott 6. (c) Age of husband or wife if alive 11 years

7. Birth date of deceased: Jan. 22 - 1889  
(Month) (Day) (Year)

8. AGE: Years 85 Months 5 Days 14 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

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

MOTHER FATHER

12. Name William C. Chancellor

13. Birthplace Jan. 1 (City, town, or county) (State or foreign country)

14. Maiden name Berquice E. Blankenship

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

16. (a) Informant S. D. Tompkins

(b) Address New Franklin Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-7-44  
(Month) (Day) (Year)

(c) Place: burial or cremation Black Chapel

18. (a) Signature of funeral director A. L. Harrison

(b) Address New Franklin Mo.

19. (a) 7-12-1944 (Date received local registrar) (b) Paul W. Miller (Registrar's signature)

Duration \_\_\_\_\_

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 labor) (c) Means of injury 2

23. Signature Dr. G. C. Holyman (M. D. or other) \_\_\_\_\_  
Address Fayette Mo. Date signed 7-12-44

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed \_\_\_\_\_

8-21-74

**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 \_\_\_\_\_

*H. L. Hall*

Licensed Embalmer No. 3515

P. O. Address New Franklin, N.J.

**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.**