

**1. PLACE OF DEATH:**  
 (a) County Texas Rural Jackson  
 (b) City or town \_\_\_\_\_  
 (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)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Mo (b) County Texas  
 (c) City or town Rural Jackson  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 7 Mi South of Jackson Mo  
 (If rural, give location) \_\_\_\_\_  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

**3. (a) PRINT FULL NAME** Albert Maywood Scott  
 8. (b) If veteran, name war \_\_\_\_\_  
 3. (c) Social Security No. \_\_\_\_\_

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH, Month Aug day 3  
 year 1944 hour 6 minute 50 P.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_, 1940, to Aug 3, 1944  
 that I last saw him alive on Aug 1, 1944  
 and that death occurred on the date and hour stated above.

4. Sex M 5. Color W 6. (a) Single, widowed, married 2 divorced  
 6. (b) Name of husband or wife Sarah Scott 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased July 28, 1873  
 (Month) (Day) (Year)

Immediate cause of death Coronary Corditis  
 Duration \_\_\_\_\_  
 Due to Prothetis  
 Due to \_\_\_\_\_

**8. AGE:** Years 71 Months - Days 5  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

**10. Usual occupation** Farming

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

**MOTHER FATHER**  
 12. Name Werton Scott  
 13. Birthplace not known Tenn  
 14. Maiden name Adeline Campbell  
 15. Birthplace not known Tenn

**16. (a) Informant** Harold Scott

**(b) Address** Raymondville Mo

**17. (a)** Burial (b) Date thereof 5-44  
 (Burial, cremation, or removal) (Month) (Day) (Year)

**(c) Place:** burial or cremation Mo Mason Cem

**18. (e) Signature of funeral director** \_\_\_\_\_

**(b) Address** Licking Mo

**19. (a)** SEPT. 29-44 (b) Mrs. Ella Duff  
 (Date received local registrar) (Registrar's signature)

**PHYSICIAN**  
 Major findings \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
 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? \_\_\_\_\_

**23. Signature** \_\_\_\_\_ (M. D. or other)  
 Address \_\_\_\_\_ Date signed 8/4/44

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

07  
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RECEIVED

District Health Officer No. 5,

District File Number 1044503

Date Filed 10-9-44

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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 Embert E. Ferguson

Licensed Embalmer No. 3945

P. O. Address Licking 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, above space should be left blank.