

FILED NOV 4 1946

Registration District No. \_\_\_\_\_

Primary Registration District No. **6070**

Registrar's No. **187**

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

400

**1. PLACE OF DEATH:**

(a) County St. Francois

(b) City or town Knob Lick  
(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 years, months or days)

In this community \_\_\_\_\_  
(Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County St. Francois

(c) City or town Knob Lick  
(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** ISABEL SCOTT

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

4. Sex Female 5. Color or race white

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

6. (b) Name of husband or wife Charles M. Scott

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

7. Birth date of deceased Jan. 27 1868  
(Month) (Day) (Year)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Oct day 6  
year 1944 hour 11 minute 30 P. M.

21. I hereby certify that I attended the deceased from Sept 16 - 1944 to Oct 6 - 1944  
that I last saw him alive on Sept 1 - 1944  
and that death occurred on the date and hour stated above.

**8. AGE:**

Years	Months	Days	If less than one day
<u>76</u>	<u>8</u>	<u>9</u>	hr. _____ min. _____

Immediate cause of death Tuberculosis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 61

9. Birthplace White County  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

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

MOTHER, FATHER {

12. Name Martin Pendergrass

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

14. Maiden name Hunterwood

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

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

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

**PHYSICIAN**  
Underline the cause to which death should be charged statistically.

16. (a) Informant Harry B. Scott

(b) Address Knob Lick, Mo.

17. (a) Burial  
(Burial, cremation, or removal) (b) Date thereof Oct. 8 1944  
(Month) (Day) (Year)

(c) Place: burial or cremation Christian Conv. Libertyville, Mo.

18. (a) Signature of funeral director Miller Funeral Home

(b) Address Farmington, Mo.

19. (a) Oct 2 - 4 1946  
(Date received local registrar) \_\_\_\_\_  
(Registrar's signature)

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 H. W. Gale (M. D., or other) \_\_\_\_\_

Address Disson, Mo. Date signed 10/17/44

1373

RECEIVED

District Health Officer No. 4  
District File Number 1144-4466  
Date Filed 11-3-44

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 Bert J. Miller  
Licensed Embalmer No. 3752  
P. O. Address Farmington, 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.