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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **41712**

Registration District No. **242**

Primary Registration District No. **4961**

Registrar's No.

1. PLACE OF DEATH:

(a) County **New Madrid**
(b) City or town **Cassala Mo**
(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 **1**
In this community **14 years**
years, months or days (Specify whether)

3. (a) PRINT FULL NAME **Margaret Evelyn Scott**

3. (b) If veteran, name war **x** 3. (c) Social Security No. **x**

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife: 6. (c) Age of husband or wife if alive, yes

7. Birth date of deceased: **9** (Month) **4** (Day) **1876** (Year)

8. AGE: Years **66** Months **7** Days **22** If less than one day hr. min.

9. Birthplace: **Ill.** (City, town, or county) (State or foreign country)

10. Usual occupation **Homemaker**

11. Industry or business:

MOTHER FATHER { 12. Name **Unknown** 13. Birthplace **Unknown** 14. Maiden name **Unknown** 15. Birthplace **Unknown**

16. (a) Informant **Miss Bessie Allen**

(b) Address **Cassala Mo**

17. (a) **Ways R. Inc.** (b) Date thereof: (Month) (Day) (Year)

(c) Place: burial or cremation **Ways Ridge Ave**

18. (a) Signature of funeral director **Johnson Funeral Home**

(b) Address **Walnut Ridge, Ark**

19. (a) **July 11 1944** (Date received by registrar) **Mae Broda** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **New Madrid**
(c) City or town **Cassala Mo 72**
(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:

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **6** day **26**
year **1944** hour **6** minute **00 P.** M.

21. I hereby certify that I attended the deceased from **6-26**
19 **44** to **6-26** 19 **44**
that I last saw him alive on **6-25** 19 **44**
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Artery Disease**

Due to **830'**

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

Major findings: Of operations: Of autopsy:

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?

(Specify type of place) (e) Means of injury

23. Signature **M. J. Jones M.D.** (M. D. or other)
Address **Worsham, Mo.** Date signed **6-26-44**

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

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

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.....

Embalmed

....., Registered Apprentice No.....

working under my personal supervision.

Signed..... *Hunter Albritton*

Licensed Embalmer No. *4210*

P. O. Address. *S. Winston*

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.