. S. No. 2
DM—8-43
v. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 16 1945

Registration District No. 42

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 9186

Primary Registration District No. 1000

Registrar's No. 194

1. PLACE OF DEATH:
(a) County BUCHANAN
(b) City or town Saint Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Saint Joseph Hospital 6
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community Six months (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Buchanan
(c) City or town Saint Joseph 11
(If outside city or town limits, write "RURAL")
(d) Street No. 124 W. Elk Street 1
(If rural, give location)
(e) Citizen of foreign country? NO 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Donald Lee Scotten
3. (b) If veteran, name war
3. (c) Social Security No. None

4. Sex Male 0
5. Color or race White
6. (a) Single, widowed, married, divorced Single 0
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased August (Month) 4 (Day) 1944 (Year)

8. AGE: Years 0 | Months 6 | Days 14 | If less than one day hr. min.

9. Birthplace Saint Joseph (City, town, or county) Missouri A (State or foreign country)
10. Usual occupation None
11. Industry or business

FATHER
12. Name William M. Scotten
13. Birthplace Andrew County (City, town, or county) Missouri 0 (State or foreign country)

MOTHER
14. Maiden name Va. Louise Butterfiedl
15. Birthplace Oklahoma City (City, town, or county) Oklahoma 1 (State or foreign country)

16. (a) Informant Mrs. Wm. M. Scotten
(b) Address 124 W. Elk Street
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Febr. 20, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Auburn Cemetery
18. (a) Signature of funeral director Mrs. E. R. SIDENFADEN
(b) Address 602 South 10th Street
19. (a) 2-20-45 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 18th year 1945 hour 5 minute 55 P. M.
21. I hereby certify that I attended the deceased from five hours 2/18/45, 19__, to 2/18/, 1945 that I last saw him alive on February 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Acute intestional indigestion complicated with acidosis 2	1 week
Due to	
Due to	
Other conditions (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? (Specify type of place)
While at work? (e) Means of injury 0

23. Signature W. M. [illegible] (M. D. or other)
Address Social Welfare Board Date signed 2/20/45

1377

(Licensed Embalmer's Statement on Reverse Side)

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 Mollie E. Sidenfaden Fo

Licensed Embalmer No. 4235

P. O. Address St Joseph 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.