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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **27928**

**FILED** AUG 21 1945  
Registration District No. **209**

Primary Registration District No. **3043**

Registrar's No. **192**

1. PLACE OF DEATH:

(a) County Marion

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

(c) Name of hospital or institution: Levering Hospital 0  
(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 Missouri (b) County Marion 64

(c) City or town Hannibal 3  
(If outside city or town limits, write "RURAL")

(d) Street No. Levering Hospital Nurses Home 4  
(If rural, give location) \_\_\_\_\_

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) 0  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Grace May Scott

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. 486-14-2012

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 29 year 1945 hour not known minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife John L. Scott 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased March 9, 1875  
(Month) (Day) (Year)

Immediate cause of death Coronary thrombosis

Duration \_\_\_\_\_

8. AGE: Years Months Days If less than one day

70 3 20 \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

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

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

9. Birthplace Monroe County Missouri 0  
(City, town, or county) (State or foreign country)

10. Usual occupation Registered Nurse

11. Industry or business Levering Hospital

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

Of autopsy None

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

MOTHER FATHER { 12. Name John M. Diez

13. Birthplace Germany 4  
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Maddox

15. Birthplace No record 9  
(City, town, or county) (State or foreign country)

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? \_\_\_\_\_

16. (a) Informant Mrs. G. E. Kenning

(b) Address Burlington Iowa

17. (a) Burial (b) Date thereof 7/2/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Grandview Burial Park

18. (a) Signature of funeral director Wm M Smith  
902 Broadway Hannibal Missouri

(b) Address \_\_\_\_\_

19. (a) 7/3/45 (b) Dr E M Lucke  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)

(c) Means of injury 3 Brown

23. Signature James D. Dineen (If P. or other) \_\_\_\_\_

Address Hannibal Date signed 7-2-45

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

4  
3  
4

**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 C. L. Gilmore

Licensed Embalmer No. 1399

P. O. Address Hannibal Missouri

**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.**