

30243

State File No. _____

FILED SEP 26 1945

Registration District No. 46

Primary Registration District No. 4063

Registrar's No. 63

1. PLACE OF DEATH:

(a) County Caldwell
 (b) City or town Hamilton
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 74 yrs. (Specify whether years, months or days)

3. (a) PRINT FULL NAME Grant Scoville

3. (b) If veteran, name war ✓ 3. (c) Social Security No. L

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife Eva Bunch 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Mar 29 1871
 (Month) (Day) (Year)

8. AGE: Years 74 Months 4 Days 13 If less than one day _____ hr. _____ min.

9. Birthplace Davis Co., Mo.
 (City, town, or county) (State or foreign country)

10. Usual occupation Laborer and fireman

11. Industry or business _____

MOTHER FATHER

12. Name Frank Scoville

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

14. Maiden name Jan M. Carey

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

16. (a) Informant Netta Bratcher
 (b) Address Hamilton Mo

17. (a) Burial (b) Date thereof Aug 13 1945
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hamilton Mo

18. (a) Signature of funeral director Bronn Farnell Howe
 (b) Address Hamilton Mo

19. (a) Aug 14 45 (b) Courine Garrett
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Caldwell 13
 (c) City or town Hamilton (If outside city or town limits, write "RURAL")
 (d) Street No. 0 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 11th
 year 1945 hour one minute thirty P.M.

21. I hereby certify that I attended the deceased from June 10th
 1945, to Aug 11 1945
 that I last saw him alive on Aug 11 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death Malnourishment of digestive tract
 Due to _____
 Due to _____

Duration

2 yrd. (?)

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

Major findings: _____
 Of operations: _____

Of autopsy None

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? _____

While at work? _____ (Specify type of place or nature of injury)

23. Signature Henry J. Carter (M.D. or other) DO.
 Address Hamilton Mo Date signed Aug 14 45

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

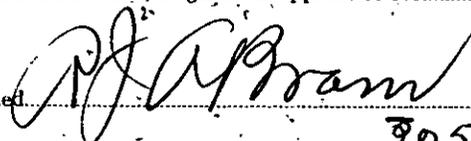
NOV 16 1945

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.....



Licensed Embalmer No. 9052

P. O. Address Hamilton 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.