

FILED NOV 28 1945

Registration District No. 72

Primary Registration District No. 4134

Registrar's No. 88

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

1. PLACE OF DEATH:

(a) County Clay

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

(c) Name of hospital or institution: Smithville Community Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days
(Specify whether)

In this community life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Clay

(c) City or town rural
(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 Anna B. Scott

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 19
year 1945 hour _____ minute _____ M.

4. Sex female 5. Color or race white

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

6. (b) Name of husband or wife Edward A. Scott

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

7. Birth date of deceased (Month) (Day) (Year)

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

Immediate cause of death: Skull Fracture
internal injuries

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

61 7 21 hr. _____ min.

Duration _____

Physician _____

Underline the cause to which death should be charged statistically.

9. Birthplace Clay Co. mo
(City, town, or county) (State or foreign country)

10. Usual occupation farmwife

Other conditions (Include pregnancy within 3 months) _____

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

11. Industry or business _____

12. Name Albert Burnett

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

14. Maiden name: Ida Miller

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

16. (a) Informant E. A. Scott

(b) Address Smithville, mo

17. (a) burial (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation I.O.O.F. Cem.

18. (a) Signature of funeral director S. A. McComas

(b) Address Smithville, mo

19. (a) Oct 21 - 1945 (b) Buckley Ritchie
(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) accident

(b) Date of occurrence Oct 19 1945

(c) Where did injury occur? Smithville Clay mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, or public place?
Home - R.F. Smithville mo
(Specify type of place) (e) Means of injury Skull Fracture

While at work _____

23. Signature John H. Norton
Address Mo. News City mo Date signed Oct 21 1945

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 11-6-45

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 S. A. McComas

Licensed Embalmer No. 2303

P. O. Address Smithville 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.

Registration District No. 72

Primary Registration District No. 4134

1. PLACE OF DEATH:

(a) County Clay

(b) City or town Smithville
(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 _____)

In this community _____ years, months or days

3. (a) PRINT FULL NAME Anna B. Scott

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

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

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

7. Birth date of deceased Feb 28 (Month) (Day) (Year)

8. AGE: Years 61 Months 7 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

MOTHER FATHER

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(Burial, cremation, or removal) (Place: burial or cremation)

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

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

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ that I last saw him _____ alive on _____ 19____ and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to Falling downstairs

Due to _____

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

Major findings: _____

Of operations _____

Of autopsy _____

Duration 166 hrs

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? Now (Specify type of place) Shell fracture
John Stearson (e) Means of injury Peronei

23. Signature John Stearson (M.D. or other) _____
Pro U.P. Mo Address _____ Date signed _____

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

SUPPLEMENTARY

33501