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5-17-39  
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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. **19884**

**FILED** JUL 11 1946

Registration District No. **76**

Primary Registration District No. **5347**

Registrar's No. **45-**

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

**1. PLACE OF DEATH:**

(a) County: Dallas

(b) City or town: Buffalo Rural  
(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 life years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State: Missouri (b) County: Dallas

(c) City or town: Buffalo Rural  
(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: \_\_\_\_\_

**3. (a) PRINT FULL NAME** IDA B. SCOTT

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

4. Sex: female 5. Color or race: white

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

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

7. Birth date of deceased: Sept 23 1864  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>81</u>	<u>9</u>	<u>4</u>	_____ hr. _____ min.

9. Birthplace: Dallas, Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation: housekeeper

11. Industry or business: \_\_\_\_\_

**MOTHER FATHER**

12. Name: David Bolinger

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

14. Maiden name: \_\_\_\_\_

15. Birthplace: \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant: Clay Scott

(b) Address: Clay State Calif

17. (a) Burial (b) Date thereof: 6-28-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Reynolds Chapel

18. (a) Signature of funeral director: L B Jones

(b) Address: Buffalo Mo

19. (a) 7-3-46 (b) D. E. Green  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month June day 27  
year 1946 hour 2 minute 35 P.M.

21. I hereby certify that I attended the deceased from May 25, 1946 to \_\_\_\_\_, 19\_\_\_\_.

that I last saw her alive on May 25, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of Colon

Duration: approx 9 mos.

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

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

Other conditions: Hypertensive Cardia 10 yrs  
(Include pregnancy within 6 months of death) vascular disease

Major findings: \_\_\_\_\_

Of operations: \_\_\_\_\_

Of autopsy: 46?

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(c) Accident, suicide, or homicide (specify) no

(b) Date of occurrence: no

(c) Where did injury occur? no  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? no

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

(e) Means of injury: no

23. Signature: Evelyn Griffin (M. D. or other) M.D.

Address: Buffalo, Mo. Date signed: 7-1-46

RECEIVED

District Health Officer No. 7,

District File Number 6-46-712

Date Filed 7-10-46

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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 Marie B. Jones

Licensed Embalmer No. 4322

P. O. Address Buffalo, 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.**