S. No. 2
M—5-43
. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 2 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

20501

State File No.

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2727

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: General Hospital No.2 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 43 mins. (Specify whether
In this community 17 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

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

(d) Street No. 734 Holmes 8
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME Olivia Mae Scott

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Female 3

5. Color or race Negro

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 September (Month) 23, (Day) 1910 (Year)

8. AGE: Years 35 Months 8 Days 22 If less than one day hr. min.

9. Birthplace Kansas City (City, town, or county) Kansas (State or foreign country) 1

10. Usual occupation Housemaid

11. Industry or business

FATHER
12. Name William W. Scott
13. Birthplace (City, town, or county) Missouri (State or foreign country) 0

MOTHER
14. Maiden name Etta Mae Hare
15. Birthplace (City, town, or county) Missouri (State or foreign country) 0

16. (a) Informant Medical Records Librarian
(b) Address General Hospital No.2

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 6-18-46 (Month) (Day) (Year)

(c) Place: burial or cremation Woodlawn K-C-R.

18. (a) Signature of funeral director Mrs J. W. Jones
K-C-Emb & Casket Co
(b) Address 440 State Ave

19. (a) 6-19-46 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 15, year 46 hour 5: minute 45 A. M.

21. I hereby certify that I attended the deceased from June 15, 5:03 A.M., 1946, to June 15, 5:45 A.M., 1946; that I last saw her alive on June 15, 1946; and that death occurred on the date and hour stated above.

Immediate cause of death PULMONARY TUBERCULOSIS BILATERAL

Due to WITH CAVITATION

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations 13 b

Of autopsy as Above

Duration

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 [signature] (M. D. or other)

Address General Hospital No.2 Date signed 6/15/46

(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. Eugene English

Licensed Embalmer No. 4105

P. O. Address. 440 State ave. K.C.

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.