

FILED SEP 16 1946 STANDARD CERTIFICATE OF DEATH

State File No. **31148**

Registration District No. **278**

Primary Registration District No. **3054**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Pike**

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

(c) Name of hospital or institution: **Mineral Springs Hospital**
(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 **Mo.** (b) County **Pike**

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

(d) Street No. **204 Iowa St.**
(If rural, give location)

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

If yes, name country _____

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

3. (b) If veteran, name war **no**

3. (c) Social Security No. **NO**

4. Sex **Female**

5. Color or race **colored**

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

6. (b) Name of husband or wife **Spencer Scott**

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

7. Birth date of deceased **March 1, 1870**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	76	6	I	hr. _____ min. _____

9. Birthplace **Pike Co. Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business **own home**

12. Name **? Smith**

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

14. Maiden name **Clara Ida Smith**

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

16. (a) Informant **Warren Scott (son)**

(b) Address **4939 Vincennes Ave. Apt. 1 Chicago, Ill.**

17. (a) **Burial**
(Burial, cremation, or removal)

(b) Date thereof **9/5/46**
(Month) (Day) (Year)

(c) Place: burial or cremation **Riverview Cem. Haley Mortuary**

18. (a) Signature of funeral director **Louisiana, Missouri**

(b) Address **19/27/46**

19. (a) **19/27/46**
(Date received local registrar)

(b) **Bernice Collier**
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **September** day **2**
year **1946** hour **12** minute **45A.** M.

21. I hereby certify that I attended the deceased from **Sept 2, 1946** to **SEPT 2, 1946**
that I last saw her **FR** alive on **SEPT. 2, 1946**
and that death occurred on the date and hour stated above.

Immediate cause of death **CARCINOMA OF STOMACH 9 MONTHS**

Due to _____

Due to _____

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

Major findings: **46B**

Of operations _____

Of autopsy _____

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) (e) MEANS OF INJURY

23. Signature **[Signature]** (M. D. or other) **90**

Address **Louisiana, Mo.** Date signed **9/2/46**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

374

SEP 27 1948

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~~.....

George O. Wagner

XXXXXXXXXXXXXXXXXXXX, Registered Apprentice No.

working under my personal supervision.

Signed *George O. Wagner*

Licensed Embalmer No. 3773

P. O. Address Louisiana, 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.