

U.S. No. 2  
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DEPARTMENT OF HEALTH  
BUREAU OF THE CENSUS  
**FILED DEC 24 1946**  
Registration District No. **128**

THE STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

State File No. **40262**  
Registrar's No. **998**

Primary Registration District No. **2000**

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

1. PLACE OF DEATH:  
(a) County **GREENE**  
(b) City or town **Springfield**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**1510 West Elm 3**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **4 months** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Mo.** (b) County **Greene**  
(c) City or town **Rogersville - RURAL**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **R. F. D. 3** (If rural, give location)  
(e) Citizen of foreign country? **No.** (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME **Addie Scott.**  
3. (b) If veteran, name war **None**  
3. (c) Social Security No. **None**

4. Sex **Female** / 5. Color or race **White**  
6. (a) Single, widowed, married, divorced **Married**  
6. (b) Name of husband or wife **Berry Scott**  
6. (c) Age of husband or wife if alive **79** years  
7. Birth date of deceased **April 5, 1872**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**74 8 7** hr. min.

9. Birthplace **Hamilton County Illinois** /  
(City, town, or county) (State or foreign country)

10. Usual occupation **House Wife.**

11. Industry or business **At Home**

MOTHER FATHER

12. Name **Andrew J. Hunt**  
13. Birthplace **Hamilton County Illinois** /  
(City, town, or county) (State or foreign country)  
14. Maiden name **Fanny Stephens**  
15. Birthplace **Hamilton County Illinois** /  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Gertrude Lowe,**  
(b) Address **1510 W. Elm, Springfield Mo.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **12/15/46**  
(Month) (Day) (Year)  
(c) Place: burial or cremation **Springfield**

18. (a) Signature of funeral director **J.W. Klingner & Co.**  
(b) Address **Springfield Mo.**

19. (a) **12/15/46** (Date received local registrar) (b) **W. E. Handy MD** (Registrar's signature)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **December** day **12** 19**46**  
year **1946** hour **5** minute **30** P.M.

21. I hereby certify that I attended the deceased from **October 7, 1946** to **December 12, 1946**;  
that I last saw her alive on **December 12, 1946**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Myocarditis with Myocardial Degeneration** **3 years**  
Due to.....

Other conditions **Carcinoma of Right Breast** **3 years**  
(Include pregnancy within 3 months of death)  
PHYSICIAN

Major findings:  
Of operations.....  
Of autopsy **50**  
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)  
Means of injury **0**  
23. Signature **Kenneth C. Coffey** (M. D. or other) **0**  
Address **Springfield, Mo.** Date signed **12-14-46**

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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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**