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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 15 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27417

State File No. _____

Registration District No. 128

Primary Registration District No. 20W

Registrar's No. 749

1. PLACE OF DEATH: **CRISIS**

(a) County _____

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

(c) Name of hospital or institution: Springfield Baptist Hospital
(If not in hospital or institution, write street number and location)

(d) Length of stay: In hospital or institution 4 days
(Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stone ¹⁰⁴

(c) City or town Blue Eye ⁰
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location) ¹

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

If yes, name country _____

3. (a) PRINT FULL NAME Scott, Mr. Frank

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

3. (c) Social Security No. _____

4. Sex M ⁰ 5. Color or race WHITE

6. (a) Single, widowed, married, divorced 7

6. (b) Name of husband or wife amy scott 6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased June 15 1853
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>94</u>	<u>2</u>	<u>10</u>	_____ hr. _____ min.

9. Birthplace Platt County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business _____

MOTHER FATHER

12. Name John L. Scott /

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

14. Maiden name Lucie Browning

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

16. (a) Informant amy scott /

(b) Address Blue Eye, Mo.

17. (a) Burial (b) Date thereof 8 25 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Blue eye mo

18. (a) Signature of funeral director R. Nelson

(b) Address Berryville Arkansas

19. (a) 9-12-47 (b) N. E. Newby MD
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 25
year 1947 hour 4:00 minute A. M.

21. I hereby certify that I attended the deceased from Aug 20 1947 to Aug 28 1947
that I last saw him alive on Aug 24 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia ^{Duration 1 week}

Due to Prostatic obstruction ^{3 yr.}

Due to _____

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

Major findings: 137 B
Of operations _____

Of autopsy _____

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? 0

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature John W. Ward (M. D. or other) MD

Address Springfield Mo Date signed 8-28-47

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

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

Rea L. Nelson

Licensed Embalmer No. *2992* Mo. *Mo.*

P.O. Address *Berryville Ark*

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.