

No. 2
1/47
17-39

FILED DEC 9 1947
Registration District No. **1956**

Primary Registration District No. **2007**

Registrar's No. _____

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

49
12
5

1. PLACE OF DEATH:

(a) County **Jasper**

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

(c) Name of hospital or institution **1016 Valley St**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **4 years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jasper**

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

(d) Street No. **1016 Valley St**
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Della L. 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 **married**

6. (b) Name of husband or wife **John F. Scott** 6. (c) Age of husband or wife if alive **68** years

7. Birth date of deceased **May 28 1882**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
65	4	11	hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business **housewife**

12. Name **Sol Rogers**

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

14. Maiden name **Frances Blankenship**

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

16. (a) Informant **John F. Scott**

(b) Address **1016 Valley St**

17. (a) **Burial** (b) Date thereat **Oct 11-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Swans Cemetery, Newton Co**

18. (a) Signature of funeral director **Thornhill-Dillon Mort**
Joplin, Missouri

(b) Address _____

19. (a) **10-9-47** (b) **Salores Tompkins D.R.**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **9**
year **1947** hour **4** minutes **30** M.

21. I hereby certify that I attended the deceased from **8-17-47**
to **10-6-47** 19____;
that I last saw her alive on **10-6-47** 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial Infarction**
Coronary

Due to **Uremia** **5 wks.**

Due to **Fracture right hip**
June 19 47

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

Major findings: **450 cc**

Of operations _____

Of autopsy _____

PHYSICIAN **1-0-6**

ADDITIONAL INFORMATION **Underline**
which death be charged to
REQUIRES FULLY.

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

(a) Accident, suicide, or homicide (specify) _____ **128**

(b) Date of occurrence **June 47**

(c) Where did injury occur? **Joplin Jasper Mo**
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **home**
(Specify type of place)

While at work? _____ (e) Means of injury **accident**

23. Signature **S. D. Scott** (M. D. or other) **D. R.**

Address **506-77th Ave Bldg - Joplin** Date signed **10-9-47**

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 Ernest M. Dungey

Licensed Embalmer No. 3566

P. O. Address Joseph Missouri

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.

Registration District No. 156

Primary Registration District No. 2001

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jasper Jasper
(b) City or town _____
(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 _____ years, months or days)

3. (a) PRINT FULL NAME Della L Scott

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced _____

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

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day hr. min. 65 10 20

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (Date received local registrar) (b) _____ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: _____ month _____ day _____ year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration

Due to _____

Due to _____

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

Major findings: 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) Fall
(b) Date of occurrence _____
(c) Where did injury occur? at home (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 Fall

23. Signature G. Martin (M. D. or other) Do

Address Jasper Mo Date signed 12-12-47

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

SUPPLEMENTARY

38080