

No. 2
-12-45
-5-17-39
X47070

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 60

1. PLACE OF DEATH:
(a) County Ruekhanon
(b) City or town St Joseph
(c) Name of hospital or institution: State Hospital # 2
(d) Length of stay: In hospital or institution 3 yrs 4 mos 4 days
In this community 3 yrs 4 mos 4 days

3. (a) PRINT FULL NAME Ima Jane Scott
3. (b) If veteran, name war nil
3. (c) Social Security No. nil

4. Sex Female 5. Color of face white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Frank Scott 6. (c) Age of husband or wife if alive 70 years
7. Birth date of deceased Dec. 27 1877

8. AGE: Years 70 Months 0 Days 25 If less than one day hr. min.

9. Birthplace Drenton Mo

10. Usual occupation House-wife

11. Industry or business at home

12. Name John Longstreth

13. Birthplace Ohio

14. Maiden name Marion Parker

15. Birthplace Ohio

16. (a) Informant Roy Chambers

(b) Address Drenton Mo

17. (a) burial (b) Date thereof 11 18 1948

(c) Place: burial or cremation Trenton Mo

18. (a) Signature of funeral director Heston-Borwan

(b) Address St. Joseph, Mo

19. (a) 1-21-48 (b) W. L. Jenkins

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Grundy
(c) City or town Drenton Mo
(d) Street No. 916 Highland Ave
(e) Citizen of foreign country? No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 17 year 1948 hour 9 minute 15 P.M.

21. I hereby certify that I attended the deceased from 1-17 1948 to 1-17 1948
that I last saw her alive on 1-17 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic pneumonia
Due to Arteriosclerosis

Duration 5 days
3 yrs +

Other conditions: (Include pregnancy within 3 months of death)
Major findings: AM
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?
(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 D. E. Cousins (M. D. or other)
Address State Hospital # 2, St Joseph, Mo Date signed 1/17/1948

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

MOTHER FATHER

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.....

Mavis Joseph Weyland Jr....., Registered Apprentice No. *444*
working under my personal supervision.

Signed *Frank A. Berman*.....

Licensed Embalmer No. *1710*.....

P. O. Address *St Joseph 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.