3. No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 5 1948

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11327

State File No.

Registration District No. 314

Primary Registration District No. 4647

Registrar's No. 10

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

1. PLACE OF DEATH:
(a) County Worth
(b) City or town Grant City
(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 64 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Worth
(c) City or town Grant City
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME William Ellsworth Scadden

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race white

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

6. (b) Name of husband or wife Mary Jane Scadden

6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased April I5 I870
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
77	II	I	hr. min.

9. Birthplace Decator County Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation day laborer

11. Industry or business

FATHER
12. Name James Scadden
13. Birthplace unknown Ohio
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Samantha Barrett
15. Birthplace unknown Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs.Mary Jane Scadden
(b) Address Grant City,Missouri

17. (a) Burial (b) Date thereof 3-I8-I948
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Grant City Cemetery

18. (a) Signature of funeral director Arch C Dunfee
(b) Address Grant City,Mo.

19. (a) March 22, 1948 (b) Leta E. Dunson
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 16
year 1948 hour 8 30 minute AM

21. I hereby certify that I attended the deceased from June
1946, to March 16 1948
that I last saw h alive on 3 — 15, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death.	Duration
Coronary Occlusion of heart	1 hr
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy No	

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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature L J Ross MD (M. D. or other)
Address Grant City Mo Date signed 3-18-48

(Licensed Embalmer's Statement on Reverse Side)

DISTRICT HEALTH OFFICE
Cameron, Mo.

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 Jack C. Dimpfee

Licensed Embalmer No. 3252

P. O. Address Grant City, 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.