

FEDERAL BUREAU OF INVESTIGATION
 MISSOURI DIVISION OF HEALTH
 STANDARD CERTIFICATE OF DEATH

FEDERAL SECURITY AGENCY
 National Office of Vital Statistics

State File No. **23822**
 Registrar's No. **239**

FILED AUG 13 1948

Registration District No. **274**

Primary Registration District No. **3052**

1. PLACE OF DEATH:
 (a) County **Pettis**
 (b) City or town **Sedalia**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Bothwell Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **3 days** (Specify whether
 In this community **Life** (Specify whether
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Pettis**
 (c) City or town **Sedalia**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **210 So. Quincy**
 (If rural, give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3. (a) PRINT FULL NAME **Wm Elmer Scotten**
 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 **Lucile**
 6. (c) Age of husband or wife if alive **58** years
 7. Birth date of deceased **Feb - 16 1882**
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
66 5 19 hr. min.

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

10. Usual occupation **Insurance**

11. Industry or business
 12. Name **R. M. Scotten**
 13. Birthplace **Howard Co. Missouri**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Rab Smith**
 15. Birthplace **London England**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Lucile Scotten**
 (b) Address **210 So. Quincy, Sedalia, Mo.**

17. (a) **Burial** (b) Date thereof **8-7-48**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Memorial Park**

18. (a) Signature of funeral director **Mc Laughlin Bros**
 (b) Address **Sedalia, Mo.**

19. (a) **8-6-48** (b) **Betty Yeager**
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **4**
 year **1948** hour **11** minute **40 P.M.**

21. I hereby certify that I attended the deceased from **7-23-48** to **8-4** 1948
 that I last saw him alive on **aug 4** 1948
 and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic interstitial nephritis**

Due to **arteriosclerosis + hypertension**

Other conditions (include pregnancy within 3 months of death) **70/10**

Duration

PHYSICIAN

Underline the cause of 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 **W. Boger** (M.D. or D.D.S.)
 Address **Sedalia, Mo.** Date signed **8-5-48**

MOTHER FATHER

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed _____

6-12-42

APR 11 1951

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 K.P. McHenry

Licensed Embalmer No. 3153

P. O. Address Sedalia 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.