No. 300
10.48

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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19779
Registrar's No. 2608

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kansas City 11
c. LENGTH OF STAY (in this place): 2mos. 9days
d. FULL NAME OF HOSPITAL OR INSTITUTION: Kansas City Tuberculosis Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Jackson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kansas City Rural 13
d. STREET ADDRESS (If rural, give location): 2127 Maddi

3. NAME OF DECEASED (Type or Print)
a. (First): Catherine
b. (Middle):
c. (Last): Scott

4. DATE OF DEATH (Month) (Day) (Year): 6 - 15 - 49

5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 8-9-1911
9. AGE (In years last birthday): 37 | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Missouri
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13a. FATHER'S NAME: James Hendrix
13b. MOTHER'S MAIDEN NAME: Mary Stumpt
14. NAME OF HUSBAND OR WIFE: Thomas Scott

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: —
17. INFORMANT'S SIGNATURE OR NAME / **ADDRESS**: Kansas City Tuberculosis Hosp.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

002X

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 4-12-, 1949, *to* 6-15, 1949, *that I last saw the deceased alive on* 6-15, 1949, *and that death occurred at* 8 45 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): G. K. Landis G. K. Landis, M.D.
23b. ADDRESS: K. C. T. B. Hosp.
23c. DATE SIGNED:

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: June 17, 1949
24c. NAME OF CEMETERY OR CREMATORY: Floral Hills Cemetery
24d. LOCATION (City, town, or county) (State): Kansas City, Missouri

DATE REC'D BY LOCAL REG.: 6-16-49
REGISTRAR'S SIGNATURE: Geraldine Holmes
25. FUNERAL DIRECTOR'S SIGNATURE / **ADDRESS**: Geo. C. Carson, Independence, Mo.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 .....

..... Student Embalmer No. .....

working under my personal supervision.

Student .....
Student Embalmer

Signed R. A. Leslie

Licensed Embalmer No. 7123

P. O. Address Independence, [illegible]

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.