

FILED JUN 18 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19781
2440

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address of location) GENERAL HOSPITAL #2		d. STREET ADDRESS (If rural, give location) 622 Harrison Street	

3. NAME OF DECEASED (Type or Print) a. (First) ERMA	b. (Middle)	c. (Last) SCOTT	4. DATE OF DEATH (Month) (Day) (Year) MAY 30 1949
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5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH MAY 18 1900	9. AGE (In years last birthday) (Months) (Days) (Hours) (Min.) 49	10. IF UNDER 1 YEAR	11. IF UNDER 4 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MISSOURI	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME RICHARD ROBERTS	13b. MOTHER'S MAIDEN NAME AMANDA BEAN	14. NAME OF HUSBAND OR WIFE Hence Scott
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. --	17. INFORMANT'S SIGNATURE OR NAME ARZELIA WALKER	ADDRESS 622 Harrison Apt. 4
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CARDIAC FAILURE		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) HYPERTENSIVE HEART DISEASE WITH DECOMPENSATION DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 443X			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 5/24/, 1949 to 5/30/, 1949 that I last saw the deceased alive on 5/30/, 1949, and that death occurred at 1:00P m., from the causes and on the date stated above.

23a. SIGNATURE <i>[Signature]</i>	23b. ADDRESS 600 East 22nd Street	23c. DATE SIGNED 5/31/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6/6/49	24c. NAME OF CEMETERY OR CREMATORY Highland	24d. LOCATION (City, town, or county) (State) Kansas City, MO
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DATE REC'D BY LOCAL REG. 6-4-49	REGISTRAR'S SIGNATURE <i>[Signature]</i>	25. FORENSIC DIRECTOR'S SIGNATURE <i>[Signature]</i>	ADDRESS 212 Vine
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(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10-48

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

E. Steubing Billa

Licensed Embalmer No. *3178*

P. O. Address *1212 Vine St, K.C., 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.