

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22640

State File No.

BIRTH NO. 40019-49 REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 756

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <u>Nebraska</u> b. COUNTY <u>Richardson</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph, Mo.</u>		c. LENGTH OF STAY (In this place) <u>1 Dys</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Falls City, Nebr.</u>		<u>999</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Mo. Methodist Hospital</u>			d. STREET ADDRESS (If rural, give location) <u>Unk</u>		

3. NAME OF DECEASED (Type or Print) a. (First) <u>Spencer</u> b. (Middle) <u>Clay</u> c. (Last) <u>Scanlan</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>July 5 1949</u>		
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5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>	8. DATE OF BIRTH <u>July 5, 1949</u>	9. AGE (In years last birthday) <u>1</u>	IF UNDER 1 YEAR Months <u>1</u>	IF UNDER 24 HRS. Hours <u>1</u>	Min. <u>2</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>St. Joseph, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

13a. FATHER'S NAME <u>Robert Scanlan</u>	13b. MOTHER'S MAIDEN NAME <u>Vere R. Davis LEWIS</u>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Robert Scanlan</u> ADDRESS <u>Falls City, Nebr.</u>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Prematurity, gestation of about 6 months, HD</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>pulmonary atelectasis.</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7625</u>
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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 July 5, 1949, to July 5, 1949, that I last saw the deceased alive on July 5, 1949, and that death occurred at 9:50P m., from the causes and on the date stated above.

23a. SIGNATURE (In presence of title) <u>Robert Scanlan MD</u>	23b. ADDRESS <u>St. Joseph, Mo.</u>	23c. DATE SIGNED <u>July 6</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>7/6/1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>July 8, 1949</u>	REGISTRAR'S SIGNATURE <u>G. C. Jenkins</u>	382	25. FUNERAL DIRECTOR'S SIGNATURE <u>Herman W. Hidergaden</u> ADDRESS <u>St. Joseph, Mo.</u>
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WILL 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 *Elmer Thomas*

Licensed Embalmer No. *2640*

P. O. Address *St Joseph*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.