

FILED JUL 25 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23246

BIRTH NO.		REG. DIST. NO. 141		PRIMARY REG. DIST. NO. 3025		Registrar's No. 78			
1. PLACE OF DEATH a. COUNTY <u>Howell</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before institution). a. STATE <u>Missouri</u> b. COUNTY <u>Howell</u>					
b. CITY (If outside corporate limits, write RURAL and give township) <u>West Plains</u>		c. LENGTH OF STAY (in table place) <u>25 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>West Plains</u>		40			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>West Plains Hosp.</u>				d. STREET ADDRESS (If rural, give location) <u>Midway Hotel</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Scott</u> b. (Middle) <u>Allen</u> c. (Last) <u>Marshall</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>6-13-49</u>						
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>W</u>		8. DATE OF BIRTH <u>2-19-1885</u>			
9. AGE (In years last birthday) <u>64</u>		IF UNDER 1 YEAR Months <u>3</u> Days <u>24</u>		IF UNDER 11 HRS. Hours <u></u> Min. <u></u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>		11. BIRTHPLACE (State or foreign country) <u>Malden, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>unk</u>			13b. MOTHER'S MAIDEN NAME <u>unk</u>		14. NAME OF HUSBAND OR WIFE <input checked="" type="checkbox"/>				
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.		17. INFORMANT'S SIGNATURE OR NAME <u>Donald Marshall, Drexler, Mo.</u>				
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, asthma, etc. It means the disease, injury, or complication which caused death.			MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral apoplexy</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Mild but hypertensive</u> DUE TO (c) <u>Nephritic interstitial</u>				<u>6 mo</u>		
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21f. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from <u>6/11</u> , 19 <u>49</u> , to <u>6/13</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>6/13</u> , 19 <u>49</u> , and that death occurred at <u>10:30</u> m., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>Maunee Thompson, M.D.</u>				23b. ADDRESS <u>West Plains, Mo.</u>		23c. DATE SIGNED			
24a. BURIAL, CREMATION, REINTERMENT (Specify)		24b. DATE <u>6/15-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Malden Cemetery, Malden, Mo</u>		24d. LOCATION (City, town, or county) (State)			
DATE REC'D BY LOCAL REG. <u>7-20-49</u>		REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>		FURNERAL DIRECTOR'S SIGNATURE <u>Robertson, West Plains, Mo</u>					

(Licensed Embalmer's Statement on Reverse Side)

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

300

48

JUL 25 1945

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

D. D. Robertson

Licensed Embalmer No. *3437*

P. O. Address *West Haven*

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

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