

FILED AUG 31 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

26706

State File No. \_\_\_\_\_

BIRTH NO. 41210-49 REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 5463 Registrar's No. 755

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

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1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Jackson Twp</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Jackson Twp</u>	
c. LENGTH OF STAY (In this place) <u>28 days</u>		d. STREET ADDRESS (If rural, give location) <u>Strafford Rt. #2</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Strafford Rt. #2</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Martha</u>	b. (Middle) <u>Kay</u>	c. (Last) <u>Scott</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>August 21 1949</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED. (Specify) <u>Single</u>	8. DATE OF BIRTH <u>24 July 1949</u>	9. AGE (In years last birthday) <u>0</u> IF UNDER 1 YEAR Months <u>0</u> Days <u>28</u> IF UNDER 2 HRS. Hours <u> </u> Min. <u> </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>	11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Ralph Scott</u>	13b. MOTHER'S MAIDEN NAME <u>Lois McKenzie</u>	14. NAME OF HUSBAND OR WIFE <u>None</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>No</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Ralph Scott</u>	ADDRESS <u>Strafford, Mo.</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, asthenia, 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) <u>Status thymic</u>		
	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 <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>		273X	

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) m.	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 7-24, 1949, to 8-21, 1949, that I last saw the deceased alive on 8-14, 1949, and that death occurred at 9:45 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>Max H. [Signature]</u>	(Degree or title) <u>M.D.</u>	23b. ADDRESS <u>Springfield Mo.</u>	23c. DATE SIGNED <u>8-23-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>8-23-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mount Comfort</u>	24d. LOCATION (City, town, or county) (State) <u>Near Springfield, Mo.</u>
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DATE REC'D BY LOCAL <u>8-24-49</u>	REGISTRAR'S SIGNATURE <u>W. E. Handley</u>	FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Klingner &amp; Co.</u>	ADDRESS <u>Spfld. Mo.</u>
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**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.

Signed.....

Signed.....  
Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

**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.