

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **37498**  
**4800**

BIRTH NO. 58067-49 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>MISSOURI</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>KANSAS CITY 0</b>		b. COUNTY <b>JACKSON</b>	
c. LENGTH OF STAY (in this place) <b>13 hrs</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>KANSAS CITY 31</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>GENERAL HOSPITAL #2</b>		d. STREET ADDRESS (If rural, give location) <b>FLORENCE HOME - 2228 Campbell Street</b>	

3. NAME OF DECEASED (Type or Print) <b>INFANT</b>	a. (First)	b. (Middle)	c. (Last) <b>SCOTT</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>SEPTEMBER 15 1949</b>
---	------------	-------------	------------------------	--

5. SEX <b>FEMALE 3</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>SEPTEMBER 15 1949</b>	9. AGE (In years - last birthday) <b>13</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 4 HRS. Hours <b>0</b>	IF UNDER 15 MIN. Min. <b>40</b>
------------------------	-------------------------------	--	---	---	---------------------------------	--------------------------------	---------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INFANT</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>KANSAS CITY, MISSOURI 0</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
---	-----------------------------------	--	--

13a. FATHER'S NAME _____	13b. MOTHER'S MAIDEN NAME <b>ORA SCOTT</b>	14. NAME OF HUSBAND OR WIFE _____
--------------------------	--	-----------------------------------

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 <b>ORA SCOTT</b>	ADDRESS <b>2228 Campbell Street</b>
--	-------------------------------	--	-------------------------------------

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) <b>MALNUTRITION</b>		
	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. <b>ATELECTASIS TO LUNG</b>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>77%</b>	20. AUTOPSY? YES <input checked="" 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) (Min.)	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 9/15/, 1949, to 9/15/, 1949, that I last saw the deceased alive on 9/15/, 1949, and that death occurred at 9:40P m., from the causes and on the date stated above.

23a. SIGNATURE <b>[Signature]</b>	23b. ADDRESS <b>600 East 22nd Street</b>	23c. DATE SIGNED <b>9/16/49</b>
-----------------------------------	--	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>11-10-49</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Leeds Cem.</b>	24d. LOCATION (City, town, or county) (State) <b>K.C. Mo.</b>
--	---------------------------	--	---

DATE REC'D BY LOCAL REG. <b>11-11-49</b>	REGISTRAR'S SIGNATURE <b>[Signature]</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. A. Schmeyer</b>	ADDRESS <b>City</b>
--	--	---	---------------------

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

*Mortician*

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 \_\_\_\_\_

*Not Embalmed*

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed *Wm A. Schmege* \_\_\_\_\_

Licensed Embalmer No. *3089* \_\_\_\_\_

P. O. Address *15 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.