

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29552

State File No. 1016

S. No. 300
EV. 10-48

LED OCT 8 1951

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 1016

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

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, mention before admission). a. STATE <u>Missouri</u> b. COUNTY <u>North</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>St Joseph Mo 2 days</u>		c. LENGTH OF STAY (In this place) <u>2 days</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Mc Hospital</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Grant City 1130</u>	
e. STREET ADDRESS <u>In city</u>		d. STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Charles</u>		b. (Middle) _____	
c. (Last) <u>Scott</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 26 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>Sept 15 1884</u>
9. AGE (In years last birthday) <u>67</u>		10. MONTHS <u>0</u> DAYS <u>11</u> HOURS <u>—</u> MIN <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Day Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm & city</u>	
11. BIRTHPLACE (State or foreign country) <u>North County, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>George Scott</u>		13b. MOTHER'S MARDEN NAME <u>Elizabeth Ross Fox Scott</u>	
14. NAME OF HUSBAND OR WIFE <u>Ray Scott</u>		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>unknown</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Ray Scott Grant City Mo</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		19. MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Cardiac</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sept 24 to Sept 26</u>	
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS Antecedent Causes Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Asma</u> DUE TO (c) _____	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>4342</u>	
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>Sept 24, 1951</u> to <u>Sept 26, 1951</u> , that I last saw the deceased alive on <u>Sept 26, 1951</u> and that death occurred at <u>6:30 P.M.</u> , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) <u>Dr. Ryan M.D.</u>		23b. ADDRESS <u>St Joseph Mo</u>	
23c. DATE SIGNED <u>Sept 26 1951</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	
24b. DATE <u>Sept 26 51</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Grant City Cemetery Grant City Mo</u>	
24d. LOCATION (City, town, or county) (State) <u>Grant City Mo</u>		25. FEDERAL DIRECTOR'S SIGNATURE <u>John Anderson Grant City Mo</u>	
DATE REC'D BY LOCAL REG. <u>October 4, 1951</u>		REGISTRAR'S SIGNATURE <u>Carl C. Casper</u>	
25. FEDERAL DIRECTOR'S ADDRESS <u>Grant City Mo</u>		26. (Licensed Embalmer's Statement on Reverse Side)	

MO

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 _____

John Andrews

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed *John Andrews*

Licensed Embalmer No. *421*

P. O. Address *Grant City 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.