

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31219**

FILED OCT 9 1951

BIRTH NO. _____ REG. DIST. NO. **814** PRIMARY REG. DIST. NO. **4439** Registrar's No. **49**

930

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

1. PLACE OF DEATH a. COUNTY St. Clair		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Kansas b. COUNTY Wyanotte	
b. CITY (If outside corporate limits, write RURAL and give township) Osceola		c. CITY (If outside corporate limits, write RURAL and give township) Kansas City - 11th - 8	
c. LENGTH OF STAY (In this place) 98 Months		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print) a. (First) Charles	b. (Middle) Raymond	c. (Last) Scott	4. DATE OF DEATH (Month) (Day) (Year) 9-18-51
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 10-6-1903	9. AGE (In years last birthday) 47	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant	10b. KIND OF BUSINESS OR INDUSTRY Retail Store	11. BIRTHPLACE (State or foreign country) Dresden Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME John A. Scott	13b. MOTHER'S MAIDEN NAME Bina Gentry	14. NAME OF HUSBAND OR WIFE Dixie Scott
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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)	16. SOCIAL SECURITY NO. 486-09-2892	17. INFORMANT'S SIGNATURE OR NAME Dixie Scott	ADDRESS Osceola Mo
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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 1 hr.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis		
	ANTECEDENT CAUSES Morbidity 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.			

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) 4201
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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?
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22. I hereby certify that I attended the deceased from **9-18** to **9-18**, 19**51**, that I last saw the deceased alive on **9-18**, 19**51**, and that death occurred at **1:30** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) T. H. J. Anglin, Jr., M.D.	23b. ADDRESS Osceola, Mo.	23c. DATE SIGNED 9-18-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9-20-1951	24c. NAME OF CEMETERY OR CREMATORY Dresden	24d. LOCATION (City, town, or county) (State) Dresden Missouri
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DATE REC'D BY LOCAL REG. 9-18-51	REGISTRAR'S SIGNATURE Walter Beecher	25. FUNERAL DIRECTOR'S SIGNATURE J. B. ...	ADDRESS Osceola Mo
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RECEIVED 10-8-51
DISTRICT HEALTH OFFICE No. 3
District File Number _____
Date Filed 10-8-51

APR 15 1952

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 J. B. Goodrich

Licensed Embalmer No. 3038

P. O. Address Osceola 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.