V.S. No. 300
Rev. 10.48

LED JAN 30 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30

BIRTH NO. _____ REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 3000 Registrar's No. 25

0013
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1. PLACE OF DEATH
a. COUNTY: Adair
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kirksville
c. LENGTH OF STAY (in this place): 3 Months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Geo. Smith Memorial Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Macon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): La Plata 0610
d. STREET ADDRESS (If rural, give location): /

3. NAME OF DECEASED (Type or Print)
a. (First): Orville
b. (Middle): P.
c. (Last): Scoville

4. DATE OF DEATH (Month) (Day) (Year): Jan 23 1952

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): M
8. DATE OF BIRTH: July 28 1880
9. AGE (In years last birthday): 71
If under 1 year: Months 5 Days 25
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farmer
11. BIRTHPLACE (State or foreign country): Mason City Illinois
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Ira Scoville
13b. MOTHER'S MAIDEN NAME: Mary Keyes.
14. NAME OF HUSBAND OR WIFE: Mrs Maude Scoville

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME: Mrs O. P. Scoville
ADDRESS: La Plata Mo

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

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized Carcinomatosis Metastasis — INTERVAL BETWEEN ONSET AND DEATH: 6 mo.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carcinoma, penis — 4 yrs.
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: 179X
20. AUTOPSY? YES ☐ NO ☑

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-19, 1951, to 1-23-, 1952, that I last saw the deceased alive on 1-23-, 1952, and that death occurred at 9:20A m., from the causes and on the date stated above.

23a. SIGNATURE: G. R. Hudson M.D. (Degree or title)
23b. ADDRESS: Kirksville, Mo.
23c. DATE SIGNED: 1-23-52

24a. BURIAL, CREMATION, REMOVAL: Burial
24b. DATE: Jan 26, 1952
24c. NAME OF CEMETERY OR CREMATORY: St. Peters Cemetery
24d. LOCATION (City, town, or county) (State): St. Louis Mo

DATE REC'D BY LOCAL REG.: 1-23-52
REGISTRAR'S SIGNATURE: Nate Lambert
25. FUNERAL DIRECTOR'S SIGNATURE: Bennetson, Wilson
ADDRESS: La Plata, Mo

(Licensed Embalmer's Statement on Reverse Side)

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

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 _____

_____, working under my personal supervision.

Student Embalmer No. _____

Signed Kenneth M. Wilson

Signed _____
Student Embalmer

Licensed Embalmer No. 4701

P. O. Address LaPlata 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.