

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7455**

FILED MAR 17 1952

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **270**

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph	
c. LENGTH OF STAY (in this place) 3 days		d. STREET ADDRESS (If rural, give location) 810 So. 13th St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Josephs Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) Helen	b. (Middle) Elizabeth	c. (Last) Scott	4. DATE OF DEATH (Month) (Day) (Year) March 4, 1952
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5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH August 15, 1906	9. AGE (In years last birthday) 45	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Tarkio, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME C. A. Berg	13b. MOTHER'S MAIDEN NAME unk.	14. NAME OF HUSBAND OR WIFE James B. Scott
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none	17. INFORMANT'S SIGNATURE OR NAME Mr. James Scott, 810 S.13th, St. Joseph, Mo.	ADDRESS
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Rupture of esophageal varices		
ANTECEDENT CAUSES		DUE TO (b) Quaternary Cirrhosis of liver	
		DUE TO (c) Lues - tertiary	
II. OTHER SIGNIFICANT CONDITIONS		Influenza pulmonary	
		6 days	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) (Min.)	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 **12-10, 1945**, to **3-4, 1952**, that I last saw the deceased alive on **3-4, 1952**, and that death occurred at **7:00 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE H. P. Senior	(Degree or title) M.D.	23b. ADDRESS St. Joseph Mo	23c. DATE SIGNED 3-6-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 3/7/1952	24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	24d. LOCATION (City, town, or county) (State) St. Joseph, Missouri
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DATE REC'D BY LOCAL OFF. MAR. 12, 1952	REGISTRAR'S SIGNATURE Carl C. Cash	25. FUNERAL DIRECTOR'S SIGNATURE Newton Bowman	ADDRESS Funeral Home St. Joseph, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

1170

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.....

William Spalding

Licensed Embalmer No. *7535*

P. O. Address *319 S. 10th St. Joseph, 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.