

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

17518

State File No.

FILED JUN 2 1953 REG. DIST. NO. 93 PRIMARY REG. DIST. NO. 4153 Registrar's No. 53-55

1. PLACE OF DEATH a. COUNTY Dade		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo		b. COUNTY Dade	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Loekwood Mo		c. LENGTH OF STAY (In this place) 2wk		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Greenfield Mo	
d. FULL NAME OF HOSPITAL OR INSTITUTION Memorial Hospital		d. STREET ADDRESS (If rural, give location) Maple st.			
3. NAME OF DECEASED (Type or Print) a. (First) Mary			b. (Middle) Ann		c. (Last) Scott
4. DATE OF DEATH (Month) (Day) (Year) May 20 1953					
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Dec 6 1879		9. AGE (In years last birthday) (Months) (Days) (Hours) (Min.) 73 5 14
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY house wife	11. BIRTHPLACE (State or foreign country) Dade so mo		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Benjiman Sharratt		13b. MOTHER'S MAIDEN NAME Rebecca Woodward		14. NAME OF HUSBAND OR WIFE T.A.Scott	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Tom Scott Greenfield 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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction			INTERVAL BETWEEN ONSET AND DEATH 2 weeks
		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.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4201			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 4-13-1953 to 5-20 , 19 53 , that I last saw the deceased alive on 5-20 , 19 53 , and that death occurred at 11:40p m., from the causes and on the date stated above.					
23a. SIGNATURE Max Heilmann M.D.			23b. ADDRESS Loekwood, Mo		23c. DATE SIGNED 5-22-53
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE may 23, 1953	24c. NAME OF CEMETERY OR CREMATORY Greenfield		24d. LOCATION (City, town, or county) (State) Greenfield M.	
DATE REC'D BY LOCAL REG. 5-26-53		REGISTRAR'S SIGNATURE J. C. Canada		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W.R. Allison Greenfield MO.	

(Licensed Embalmer's Statement on Reverse Side)

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

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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

W. R. Allison

Licensed Embalmer No. *4404*

P. O. Address *Shreveport*

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.