

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **31997**  
Registrar's No. **4594**

FILED OCT 15 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002**

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Kansas City</b>		c. LENGTH OF STAY (in this place) <b>8 mos.</b>	c. CITY OR TOWN <b>Laurel</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>20 East 53 Terr.</b>			e. STREET ADDRESS (If rural, give location) <b>211 Patuxent Road</b>		
3. NAME OF DECEASED (Type or Print) a. (First) <b>MRS. IRENE</b>		b. (Middle) <b>LOVELL</b>	c. (Last) <b>SCOTT</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>9-21-53</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>9-28-1871</b>	9. AGE (In years last birthday) <b>81</b>	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>Philadelphia, Pa. /</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>Eli Duvall</b>		13b. MOTHER'S MAIDEN NAME <b>Alice Ball</b>		14. NAME OF HUSBAND OR WIFE <b>Henry Martin Scott</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Col. Geo. G. Davies, 20 E. 53 Terr., K.C.MO.</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>			MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pulmonary Embolus</b> ANTECEDENT CAUSES DUE TO (b) <b>Fractured left hip</b> DUE TO (c) <b>Malaria</b> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Generalized arteriosclerosis</b>		
19a. DATE OF OPERATION <b>9-3-53</b>			19b. MAJOR FINDINGS OF OPERATION <b>Fractured hip - pinned.</b>		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)		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 <b>8-1</b> , 1953, to <b>9-21</b> , 1953, that I last saw the deceased alive on <b>9-21</b> , 1953, and that death occurred at <b>2:30 P.M.</b> , from the causes and on the date stated above.					
23a. SIGNATURE <b>W. A. Slentz</b> (Degree or title) <b>M.D.</b>			23b. ADDRESS <b>315 Nichols Rd. Kansas City, Mo.</b>		23c. DATE SIGNED <b>9/21/53</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>9-22-53</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Upperville Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Upperville, Virginia</b>
DATE REC'D BY LOCAL REG. <b>9-22-53</b>		REGISTRAR'S SIGNATURE <b>Sheldine Smith</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>STINE &amp; McCLURE UND. CO. K.C.MO.</b>	

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

Dr. W. A. Slenty

441 West 59 Texas.

TOD 2:15 PM

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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.....  
Signature of Student Embalmer

Signed.....  
*Eugene T. Kemmer*

Licensed Embalmer No. 4633

P. O. Address Kansas City

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.