

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

8921

BIRTH NO. FILED MAR 25 1954 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 1020

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE Missouri b. COUNTY De Kalb	
b. CITY (If outside corporate limits, write RURAL and give town) Kansas City		c. LENGTH OF STAY (in this place) 6 days	c. CITY OR TOWN Mayview
d. FULL NAME OF HOSPITAL OR INSTITUTION Vets Administration Hospital		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
e. STREET ADDRESS (If rural, give location) Mayview, Missouri		0320	
3. NAME OF DECEASED (Type or Print) a. (First) Leonard b. (Middle) C. c. (Last) SCOTT		4. DATE OF DEATH (Month) (Day) (Year) March 5, 1954	
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 12-12-83
9. AGE (In years last birthday) 70		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter	11. BIRTHPLACE (City and State or Foreign Country) Odessa Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Albert Scott	
13b. MOTHER'S MAIDEN NAME Sarah Mauzy		14. NAME OF HUSBAND OR WIFE Pearl S. Scott	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes: WW I		16. SOCIAL SECURITY NO. unkn	
17. INFORMANT'S SIGNATURE OR NAME Files of Veterans Administration		ADDRESS	
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) Cerebral vascular accident ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Pneumonia, bronchial DUE TO (c)	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 4 days 3 days 331X	
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) / VA	
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 February 26 1954 , to March 5, 1954 , and that death occurred on March 5, 1954 , and that death occurred at 3:45 p. m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) W. A. Leo, M.D.		23b. ADDRESS VAH, Kansas City, Missouri	
23c. DATE SIGNED 3-5-54		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE Mar. 7, 1954		24c. NAME OF CEMETERY OR CREMATORY Mayview Cemetery	
24d. LOCATION (City, town, or county) (State) Mayview, Missouri		25. FUNERAL DIRECTOR'S SIGNATURE Husman - Sparks	
25. ADDRESS Odessa, Mo.		DATE REC'D BY LOCAL REG. 3-6-54	
REGISTRAR'S SIGNATURE Geraldine Smith		ADDRESS	

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 Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed..... *William K. Camp*

Licensed Embalmer No. *772*

P. O. Address..... *H. C. 2*

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.