

FILED AUG 8 - 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 21557
Registrar's No. 55

BIRTH NO. _____ REG. DIST. NO. 75 PRIMARY REG. DIST. NO. 3015

1. PLACE OF DEATH a. COUNTY Clinton		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Casswell	
b. CITY OR TOWN Cameron		c. CITY OR TOWN Kidder	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) 2 days		e. STREET ADDRESS (If rural, give location) 01301	
d. FULL NAME OF HOSPITAL OR INSTITUTION Cameron Hosp.			

3. NAME OF DECEASED (Type or Print) a. (First) Elgie b. (Middle) May c. (Last) SCOTT	4. DATE OF DEATH (Month) (Day) (Year) July 29 - 1955
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH April 8, 1897	9. AGE (years last birthday) 78	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and State or Foreign Country) Versailles Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME E. C. Frost	13b. MOTHER'S MAIDEN NAME Dehoney Taylor	14. NAME OF HUSBAND OR WIFE William A. Scott
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) -	16. SOCIAL SECURITY NO. 707-05-2397	17. INFORMANT'S SIGNATURE OR NAME William A. Scott	ADDRESS Kidder Mo
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 6 hrs
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cancer of Caecum		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cancer of Caecum DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 153X			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Ca of Caecum	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (m.)	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 **3-3**, 1955, to **7-28**, 1955, that I last saw the deceased alive on **7-28**, 1955, and that death occurred at **7:30 a.m.** from the causes and on the date stated above.

23a. SIGNATURE [Signature] (Degree or title)	23b. ADDRESS [Address]	23c. DATE SIGNED 7-29-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 7-30-55	24c. NAME OF CEMETERY OR CREMATORY Versailles Cemetery	24d. LOCATION (City, town, or county) (State) Versailles Mo
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DATE REC'D BY LOCAL REG. 8-3-55	REGISTRAR'S SIGNATURE Winifred W. Moser	25. FUNERAL DIRECTOR'S SIGNATURE Tom Moss	ADDRESS CRUNK Cameron Mo
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(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, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Laurence J. Thompson*

Licensed Embalmer No. *47*

P. O. Address *Camden*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.