

FILED NOV 21 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **37633**BIRTH NO. _____ REG. DIST. NO. **254** PRIMARY REG. DIST. NO. **5860** Registrar's No. **56**

1. PLACE OF DEATH a. COUNTY Oregon		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Oregon	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural (Big Apple)		c. LENGTH OF STAY (in this place) 8 years	
d. FULL NAME OF HOSPITAL OR INSTITUTION		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural (Big Apple)	
		d. STREET ADDRESS (If rural, give location) 0150	

3. NAME OF DECEASED (Type or Print) a. (First) Jesse b. (Middle) Franklin c. (Last) Scott			4. DATE OF DEATH (Month) (Day) (Year) November 10, 1955		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, / WIDOWED, DIVORCED (Specify) Married	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Section Foreman		10b. KIND OF BUSINESS OR INDUSTRY Railroad		8. DATE OF BIRTH 9-6-1882	
				9. AGE (In years last birthday) 73	
				11. BIRTHPLACE (City and State or Foreign Country) Kearney, Nebraska	
				12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME W. A. Scott		13b. MOTHER'S MAIDEN NAME Sarah Cooper		14. NAME OF HUSBAND OR WIFE Ella 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. 707-09-0973		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Ella Scott, Koshkonong, Missouri	

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) Coronary Thrombosis			INTERVAL BETWEEN ONSET AND DEATH
		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. 4201			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			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) m.		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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **11:30 AM**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Lee Ocas Martin, Coronar J. Keyser, MD			23b. ADDRESS Mo		23c. DATE SIGNED 11-14-55		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 11-17-1955		24c. NAME OF CEMETERY OR CREMATORY Hemingford Cemetery		24d. LOCATION (City, town, or county) (State) Hemingford, Nebraska	
DATE REC'D BY LOCAL REG. 11-14-55		REGISTRAR'S SIGNATURE Arthur Wolff		25. FUNERAL DIRECTOR'S SIGNATURE Edward Carter		ADDRESS Shagers Dr	

(Licensed Embalmer's Statement on Reverse Side)

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 _____

Leland Carter

Licensed Embalmer No. 4571

P. O. Address Raymond

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to do the above constitutes grounds for revocation of license.)

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