

Diseases in Part I must be casually related. Carer cannot certify to a death due to natural causes. All symptoms will be listed. All symptoms in Part I must be casually related. Carer cannot certify to a death due to natural causes. All symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED SEP 18 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31122
STATE FILE NUMBER

Registration District No. 156 Primary Registration District No. 2001 Registrar's No. 397

| | | | | | |
|--|--|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Jasper | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jasper | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Joplin, Missouri | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN Rt 1 Oronogo, Mo | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hosp. | | Length of stay in lb 5 Weeks | d. STREET ADDRESS (If outside, give location) 16 Miles N. of Webb City Mo | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Ira Middle Orval Last Scott | | | 4. DATE OF DEATH Sept. 4, 1956 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Apr. 26, 1904 | 9. AGE (In years last birthday) 52 | IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee Quaker Oats Co. Joplin Mo | | 10b. KIND OF BUSINESS OR INDUSTRY Co. Joplin Mo | 11. BIRTHPLACE (City and state or country) Rt 1 Oronogo, Mo. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Ira Scott | | | 14. MOTHER'S MAIDEN NAME Sylvia Redden | | |
| 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. 500-10-5296 | 17. INFORMANT Mrs. Ira. Scott Rt 1 Oronogo Mo | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchiogenic Carcinoma Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) with generalized metastases to Lungs & Liver etc. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 162x | | | | | INTERVAL BETWEEN ONSET AND DEATH 6 months |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Hour _____ a. m. _____ p. m. | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION | | COUNTY STATE |
| 21. I attended the deceased from 7-31-56 to 9-4-56 and last saw her alive on 9-4-56 Death occurred at 7:10 P.M. on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) Walter Howard M.D. | | | 22b. ADDRESS Fused Bldg. Joplin Mo | | 22c. DATE SIGNED 9/6/56. |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE Sept. 7, 1956 | 23c. NAME OF CEMETERY OR CREMATORY Nashville Cemetery | | 23d. LOCATION (City, town, or county) (State) Nashville, Missouri | |
| 24. FUNERAL DIRECTOR Johnston-Arnice-Simpson Mortuary | | ADDRESS Webb City, Mo | 25. DATE RECD. BY LOCAL REG. 9-10-1956 | 26. REGISTRAR'S SIGNATURE Novie Merriam | |

Webb City, Mo (Licensed Embalmer's Statement on Reverse Side)

File Number 56-9-734
Date filed SEP 17 1956

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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 Harvey E. Amico
Licensed Embalmer No. 44

P. O. Address Wellington

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