THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED JAN 13 1958

STATE FILE NUMBER 982

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 18

1. PLACE OF DEATH
a. COUNTY Greene
b. CITY OR TOWN Springfield — Inside Limits Yes ☐ No ☒
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) D.O.A.Baptist Hosp. — Length of stay in Hospital 44 Yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Greene
c. CITY OR TOWN Springfield — Inside Limits Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) 916 W. Elm — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First RALPH Middle JAMES Last SCOTT

4. DATE OF DEATH: Month January Day 3 Year 1958

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 1 Sept. 1913
9. AGE (In years last birthday) 44 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postal Employee
10b. KIND OF BUSINESS OR INDUSTRY Retired
11. BIRTHPLACE (City and state or country) Springfield, Missouri
12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME William J. Scott
13b. MOTHER'S MAIDEN NAME Zadie Ward
14. NAME OF HUSBAND OR WIFE Doris Scott
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. ?
17. INFORMANT Doris Scott Address Springfield, Mo.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH 20 Min.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Coronary Arterial Occlusion
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4201
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 11-3-52, to 1-3-58 and last saw him alive on 7-6-57
Death occurred at 5:10 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE [signature] (Degree or title) MD
22b. ADDRESS Springfield, Missouri
22c. DATE SIGNED 1-8-58

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 1-8-58
23c. NAME OF CEMETERY OR CREMATORY Greenlawn
23d. LOCATION (City, town, or county) Springfield, Missouri (State)

24. FUNERAL DIRECTOR J.W. Klingner & Co. ADDRESS Spgfd. Mo.
25. DATE RECD. BY LOCAL REG. 1-9-58
26. REGISTRAR'S SIGNATURE Edith Williamson

(Licensed Embalmer's Statement on Reverse Side)

JAN 15 1958

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalme

by me, or by ....., Student Embalmer No. .....

working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed .....

Licensed Embalmer No. 407

P. O. Address .....

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.