

Health,
& Welfare
Public
Service

5. 300
1-57
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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

HEALTH DEPARTMENT OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-026357
STATE FILE NUMBER

Registration District No. 211 Primary Registration District No. 5828 Registrar's No. 23

1. PLACE OF DEATH a. COUNTY <u>NEW MADRID</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>TENNESSEE</u> b. COUNTY <u>TIPTON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>LE SIEUR TWP.</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>TIPTONVILLE</u> 811 1/2 Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle Last <u>SCOTT</u>			4. DATE OF DEATH Month <u>JULY</u> Day <u>27</u> Year <u>1958</u>	
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 4 1914</u>	9. AGE (In years last birthday) <u>43</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	11. BIRTHPLACE (City and state or country) <u>JACKSON, TENN.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>WILL SCOTT</u>	13b. MOTHER'S MAIDEN NAME <u>EMMA WHITEFIELD</u>	14. NAME OF HUSBAND OR WIFE <u>ROSE SCOTT</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>411-44-0249</u>	17. INFORMANT <u>ROSE SCOTT</u> Address <u>TIPTONVILLE, TENN.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Car hit bridge, fractured skull</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Skull</u>	
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <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 <u>872</u> COUNTY STATE
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21. I attended the deceased from _____, to _____, and last saw her/him alive on _____.
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Ed Hedges</u> (Degree or title) <u>3</u>	22b. ADDRESS <u>Clonius New Madrid Mo</u>	22c. DATE SIGNED <u>July 29-58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>JULY 28, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>TIPTONVILLE CEMETERY</u>	23d. LOCATION (City, town, or county) (Specify) <u>TIPTONVILLE TENN.</u>
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24. FUNERAL DIRECTOR <u>HUDSON FUNERAL HOME</u>	ADDRESS <u>Dyersburg, Tenn</u>	25. DATE RECD. BY LOCAL REG. <u>7-30-58</u>	26. REGISTRAR'S SIGNATURE <u>Ellen Hejlic Molen</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

DATE RECEIVED AUG 6 1958
NEW MADRID CO. HEALTH CENTER

A. G. S.

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 Joseph A. DeLise
4481
Licensed Embalmer No.
P. O. Address Polkville Mo

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.