

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-020247

STATE FILE NUMBER

19

FILED MAY 18 1959

Registration District No. 378

Primary Registration District No. 4552

Registrar's No.

pt. Health,
, & Welfare
S. Public
lth Service

S. 300
v. 1-57

securing the medical certification in the specific manner required by 192.140 N.M.S. 1947.
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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Wright</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Wright</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mtn Grove,</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Mtn Grove</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>At Home</u>		Length of stay in 1b <u>3 months</u>	d. STREET ADDRESS (If outside, give location) <u>114 1/2 R # 2 Box 7C</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Robert E. Lee Scarlet</u>			4. DATE OF DEATH Month Day Year <u>May 6, 1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>9-16-1903</u>		9. AGE (In years last birthday) <u>56</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (City and state or country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>
13a. FATHER'S NAME <u>Maderson Scarlet</u>		13b. MOTHER'S MAIDEN NAME <u>Liza Whitehead</u>		14. NAME OF HUSBAND OR WIFE -----	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>491-16-7598</u>	17. INFORMANT Address <u>Gladys Belt Mtn. Grove, Missouri</u>		
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>Diabetes Mellitus</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Not known</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>-</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) <u>260x</u>					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.)		
20c. TIME OF INJURY Hour a.m. Month, Day, Year 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.) <u>Highway 4 - 114 1/2 S.W.</u>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>May 4 1959</u> to <u>May 6 1959</u> and last saw her alive on <u>May 6 1959</u> Death occurred at <u>7:45</u> a m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Del Courser M.D.</u>			22b. ADDRESS <u>Mountain View Mo</u>		22c. DATE SIGNED <u>5-7-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>5-6-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodland Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Campbell, Missouri</u>
24. FUNERAL DIRECTOR <u>Ewell C. Craig</u>			25. DATE RECD. BY LOCAL REG. <u>5-9-1959</u>		REGISTRAR'S SIGNATURE <u>Bernice L. Silverman</u>

County File Number
Date Filed 5-11-59

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 *Cecil C. Craig*

Licensed Embalmer No. *4766*

P. O. Address *Mt. Grove, Pa.*

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.