

**MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**FILED VS DEC 21 1959**

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**5913**

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. \_\_\_\_\_

AMENDED

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u>		Length of stay in lb <u>2 yrs.</u>		c. CITY OR TOWN <u>Kansas City</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>529 S. Drury</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>529 S. Drury</u>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>George Scott</u> Last _____				4. DATE OF DEATH Month <u>12</u> Day <u>7</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>10-29-1892</u>	
9. AGE (last birthday) <u>67</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Autoline Co</u>		11. BIRTHPLACE (City and state or country) <u>Carroll County Mo</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>							
13a. FATHER'S NAME <u>W.H. Scott</u>			13b. MOTHER'S MAIDEN NAME <u>Jenny Huddleston</u>			14. NAME OF HUSBAND OR WIFE <u>Ella M. Scott</u>	
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>492-14-4308</u>		17. INFORMANT <u>William V. Scott</u> Address <u>8838 Minnie St. No. 16 K.C. Mo.</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>Acute Pulmonary Hemorrhage</u> DUE TO (b) <u>Carcinoma of Rt. Lung</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>Immed.</u> <u>6 mos ±</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) <u>Pulmonary Emphysema &amp; Fibrosis</u>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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. _____ p.m. Month, Day, Year _____		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 <u>Oct 16, 1959</u> to <u>Death</u> and last saw him alive on <u>12/7/59</u> Death occurred at <u>home</u> at <u>2:30</u> P.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Frank Dean Ost, M.D.</u>				22b. ADDRESS <u>5111 Arden Ave K.C., Mo.</u>		22c. DATE SIGNED <u>12/8/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12-9-1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Meriah Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City Missouri</u>	
24. FUNERAL DIRECTOR <u>C. J. Blackman &amp; Son, Inc. K.C. Mo.</u> ADDRESS _____				25. DATE RECD. BY LOCAL REG. <u>12-8-59</u>		26. REGISTRAR'S SIGNATURE <u>new minshall</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Frank Dean Ost

**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 W.C. Quinn

Licensed Embalmer No. 4879

P. O. Address N.C., 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.