

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-003041

FILED VS JAN 19 1960

316

Primary Registration District No. 3059

Registrar's No. 4

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <b>St. Francois</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Francois</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Bonne Terre</b>		Length of stay in 1b <b>2 days</b>		c. CITY OR TOWN <b>Farmington</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Bonne Terre Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Todd</b> Middle <b>Lane</b> Last <b>Scott</b>				4. DATE OF DEATH Month <b>January</b> Day <b>2</b> Year <b>1960</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 31, 1959</b>	9. AGE (last birthday) <b>2</b>	IF UNDER 1 YEAR Months <b>2</b> Days	IF UNDER 24 HR Hours <b>2</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (City and state or country) <b>Bonne Terre, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Eugene Scott</b>			13b. MOTHER'S MAIDEN NAME <b>Patricia Keifer</b>			14. NAME OF HUSBAND OR WIFE <b>None</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Eugene Scott Farmington, Missouri</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prenatality</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 <b>12-31-59</b> to <b>1-2-60</b> and last saw him alive on <b>1-2-60</b> Death occurred at <b>7:42 P.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <b>F. R. Crocker MD</b> (Degree or title)				22b. ADDRESS <b>Farmington Mo.</b>			22c. DATE SIGNED <b>1-4-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1/4/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hillview Memorial Gardens</b>		23d. LOCATION (City, town, or county) <b>Farmington, Missouri</b>		(State)	
24. FUNERAL DIRECTOR <b>Miller Funeral Home Farmington, Mo.</b> ADDRESS				25. DATE RECD. BY LOCAL REG. <b>Jan. 4, 1960</b>		26. REGISTRAR'S SIGNATURE <b>Ether Reddy</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

*Not Embalmed*

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

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed *Paul Dugal*

Licensed Embalmer No. *4120*

P. O. Address *Farmington*

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.