

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-023752

FILED VS JUN 20 1960
 ENDED

Registration District No. 385 Primary Registration District No. 3039 Registrar's No. 127

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>LINN</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>LINN</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MARCELINE</u>		Length of stay in 1b		c. CITY OR TOWN <u>MARCELINE</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>CHICAGO ST</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>CHICAGO ST.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>TOM</u> Middle Last <u>SCOTT</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>4</u> Year <u>1960</u>				
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</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>5-31-1892</u>	9. AGE (last birthday) <u>68</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>4</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>		11. BIRTHPLACE (City and state or country) <u>CHARITON Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>JIM SCOTT</u>			13b. MOTHER'S MAIDEN NAME <u>MARY BENEDICT</u>			14. NAME OF HUSBAND OR WIFE <u>AMY 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>UNKNOWN</u>		17. INFORMANT Address <u>LUEILLE MALLOY BUCKLIN 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>Carcinomatosis due to Carcinoma</u> DUE TO (b) <u>of the 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	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Carbon disulphide; Phlebotomy</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 checked="" 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 1959</u> to <u>June 4 1960</u> and last saw him alive on <u>June 4, 1960</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>George J. Miller</u> (Degree or title)				22b. ADDRESS <u>Marceline Missouri</u>			22c. DATE SIGNED <u>6-6-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>6-6-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive CEM.</u>		23d. LOCATION (City, town, or county) (State) <u>MARCELINE Mo.</u>			
24. FUNERAL DIRECTOR <u>Miller-Tidotson</u> ADDRESS <u>MARCELINE Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>6-6-60</u>		26. REGISTRAR'S SIGNATURE <u>Broovie Owens</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUN 21 1960

STATEMENT BY LICENSED EMBALMER

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 Silburn K. Tildate

Licensed Embalmer No. 4508

P. O. Address Marshall

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.