

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-031427

EP 2 1960

STATE FILE NUMBER

Registration District No. 240 Primary Registration District No. 4358 Registrar's No. 18

NDED

1. PLACE OF DEATH a. COUNTY <u>New Madrid</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>New Madrid</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Lilbourn</u>		Length of stay in 1b <u>Life</u>	c. CITY OR TOWN <u>Lilbourn</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>Baehr Rd.</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Baehr Rd</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Clay</u> Middle <u>Scott</u> Last <u>Scott</u>			4. DATE OF DEATH Month <u>August</u> Day <u>14</u> Year <u>1960</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>5-31-82</u>	9. AGE (last birthday) <u>81</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>13</u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>New Madrid Co., Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Linn Scott</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Mary L. 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>None</u>	17. INFORMANT <u>Mary L. Scott-Lilbourn, Mo.</u> Address		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>18 mo</u> <u>2 years</u>
IMMEDIATE CAUSE (a) <u>Bronchial pneumonia</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Malnutrition</u>		
	DUE TO (c) <u>Carcinoma bowel</u>		

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		
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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 <u></u> a.m. <u></u> p.m. <u></u>	Month, Day, Year <u></u>				
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 June 4, 1960 to August 14, 1960 and last saw her/him alive on August 14, 1960
Death occurred at 11: P. M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Daniel R. Henaley MD</u> (Degree or title)		22b. ADDRESS <u>211 E 3rd Lilbourn</u>		22c. DATE SIGNED <u>8/16/60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8-16-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mounds Park Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Near Lilbourn, Missouri</u>	
24. FUNERAL DIRECTOR <u>Ponder Funeral Home-Lilbourn, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>8-16-1960</u>	26. REGISTRAR'S SIGNATURE <u>H. L. Ponder Deputy</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MS SEP 2 - 1960

Dr. Hensley

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 David J. Powell

Licensed Embalmer No. 5030
P. O. Address Follow

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.