

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH						-61-021455		
DEPARTMENT OF PUBLIC HEALTH AND WELFARE						STATE FILE NUMBER		
AMENDED		Registration District No. 139		Primary Registration District No. 1002		Registrar's No. 2978		
FILED JUN 28 1961								
DATE AMENDED	1. PLACE OF DEATH a. COUNTY Jackson			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Missouri COUNTY Jackson				
	b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City			Length of stay in 1b 43 Yrs.	c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
	c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Trinity Lutheran			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1015 East Armour Blvd.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
	3. NAME OF DECEASED (Type or print) First WILLIAM Middle RAY Last SCOTT			4. DATE OF DEATH Month June Day 14 , Year 1961				
	5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-27-1884	9. AGE (last birthday) 76	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR.	
	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Stock Room Mgr. of Bruce Dodson			10b. KIND OF BUSINESS OR INDUSTRY Bruce Dodson	11. BIRTHPLACE (City and state or country) Tarzwil, Virginia	12. CITIZEN OF WHAT COUNTRY U. S. A.		
	13a. FATHER'S NAME Winfield Scott			13b. MOTHER'S MAIDEN NAME Fannia A. Crabtree		14. NAME OF HUSBAND OR WIFE Bessie G. Scott		
	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Bessie G. Scott		Address Kansas City, Mo.	
	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
	IMMEDIATE CAUSE (a) Broncho-pneumonia			DUE TO (b) Cachexia			DUE TO (c) Ca of Rectum	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								2 mo
								1 yr
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 _____ 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 June 7 , to June 14 and last saw him alive on June 13 Death occurred at 1115 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) John M. Powers, M.D.			22b. ADDRESS 3309 Ashwood			22c. DATE SIGNED 6/14/61		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6-16-61	23c. NAME OF CEMETERY OR CREMATORY Mt. Washington	23d. LOCATION (City, town, or county) Kansas City, Mo.					
24. FUNERAL DIRECTOR Freeman Mortuary	ADDRESS Kansas City, Mo.	25. DATE RECD. BY LOCAL REG. 6-14-61	26. REGISTRAR'S SIGNATURE Ruth H. Long					

The John Powers

3304 Greenwood

WA. 4-9244

1-5

STATEMENT BY LICENSED EMBALMER

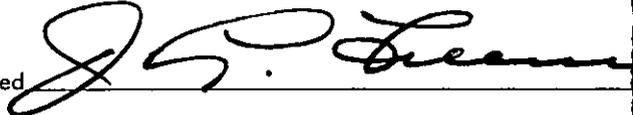
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed 

Licensed Embalmer No. 293

P. O. Address F. O. W.

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.