

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

**1. PLACE OF DEATH**

County DeKalb  
Township Washington  
City Clarksdale (No. \_\_\_\_\_)

Registration District No. 258  
Primary Registration District No. 5360A

File No. 23927  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

John L. Scott

(a) Residence No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX**

male

**4. COLOR OR RACE**

white

**5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)**

Married

**5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF**

Ruth Scott

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)**

Feb. 9, 1886

**7. AGE**

YEARS

MONTHS

DAYS

IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

48

5

8

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work

Radiotrician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

**9. BIRTHPLACE (CITY OR TOWN)**

Maysville

(STATE OR COUNTRY)

Missouri

**10. NAME OF FATHER**

Wm. J. Scott

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

Ireland

**12. MAIDEN NAME OF MOTHER**

Mary Hofstatter

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

Wisconsin

**14. INFORMANT**

(Address)

Mrs. John L. Scott  
Clarksdale, Mo.

**15. FILED**

7-19, 1934

Mrs. P. O. Davis  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)**

July 17, 1934

**17.**

HEREBY CERTIFY, That I attended deceased from

July 17, 1934, to July 17, 1934  
that I first saw him alive on July 17, 1934, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Pulmonary Tuberculosis.  
23A

11A (duration) \_\_\_\_\_ yrs. mos. ds.

**CONTRIBUTORY (SECONDARY)**

Influenza began 1927. (duration) \_\_\_\_\_ yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Samuel H. [Signature], M. D.

7/18, 1934 (Address) Maysville Mo.

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY; and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL**

**DATE OF BURIAL**

19

**20. UNDERTAKER**

E. G. [Signature] Stewartville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

AUG 16 1934

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