S. No. 2
1—8-43
5-17-39
P I X37823

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 41846

FILED DEC 29 1945

Registration District No. 2097 Primary Registration District No. 3043 Registrar's No. 349

1. PLACE OF DEATH:

(a) County Marion
(b) City or town Hannibal
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1905 Chestnut St. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether
In this community 65 years. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (g) County Marion 64
(c) City or town Hannibal 3
(If outside city or town limits, write "RURAL")
(d) Street No. 1905 Chestnut 4
(If rural, give location)
(e) Citizen of foreign country? No 0 (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME Sarah Emma Scott

3. (b) If veteran, name war ____ 3. (c) Social Security No. ____

4. Sex Female | 5. Color or race White | 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife John W. Scott | 6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased November (Month) 7 (Day) 1850 (Year)

8. AGE:	Years	Months	Days	If less than one day
	95	0	5	____ hr. ____ min.

9. Birthplace Fairfield (City, town, or county) Illinois (State or foreign country)
10. Usual occupation Housewife
11. Industry or business ____

MOTHER FATHER
12. Name Robert B. Robinson
13. Birthplace ____ (City, town, or county) Illinois (State or foreign country)
14. Maiden name Sarah Patterson
15. Birthplace ____ (City, town, or county) Kentucky (State or foreign country)

16. (a) Informant Mrs Howard Mason
(b) Address 1905 Chestnut, Hannibal, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 14 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Riverside Cemetery
18. (a) Signature of funeral director Roy P. Schuyler
(b) Address 1010 Broadway, Hannibal, Mo.
19. (a) 11-20-45 (Date received local registrar) (b) W. E. McLucke (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 12
year 1945 hour 9 minute 25 P.M.
21. I hereby certify that I attended the deceased from August 10th, 1943, to November 11, 1945
that I last saw her alive on November 11, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Arteriosclerosis,	
Coronary sclerosis	2 yrs
Due to Senility	ago
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations ____
Of autopsy ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) ____
(b) Date of occurrence ____
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ____
While at work? (Specify type of place) (e) Means of injury ____

23. Signature Fredrick B. Spencer (M. D. or other)
Address 1910 Market, Hannibal Mo. Date signed 11/16/45

1894 (Licensed Embalmer's Statement on Reverse Side)

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 .....

....., Registered Apprentice No. .....,

working under my personal supervision.

Signed George T. Bond

Licensed Embalmer No. 4373

P. O. Address Hannibal Mo

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 this body is not embalmed, fact should be so stated above.