

JUN 24 1927

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

Do not use this space.

14234

1. PLACE OF DEATH
County..... Buchanan Registration District No. 1001
Township..... Washburn Primary Registration District No.
City..... St. Joseph (No.) St. Ward

File No.
Registered No. 523

2. FULL NAME Charles N. Scarlett
(a) Residence. No. 913 S. 20th St. Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 11 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

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 Elizabeth Scarlett
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 25, 1862
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 64 6 20
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work retired farmer (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Indiana (STATE OR COUNTRY)

10. NAME OF FATHER Charles Scarlett
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ind. (STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Edna Edwards
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ind. (STATE OR COUNTRY)

14. INFORMANT Elizabeth Scarlett (Address) 913 S. 20th City of St. Joseph

15. FILED 10 19 1927 John G. [Signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 15 1927
17. I HEREBY CERTIFY, That I attended deceased from May 14 1927, to May 15 1927, and that I last saw him alive on May 14 1927, and that death occurred, on the date stated above, at 11:50 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Lobar Pneumonia
108
106 B / 01 A (duration) yrs. mos. 2 da.

CONTRIBUTORY Chronic Bronchitis (SECONDARY) (duration) 15 yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH.

0 DID AN OPERATION PRECEDE DEATH. No. DATE OF

WHAT TEST CONFIRMED DIAGNOSIS Clinical (Signed) [Signature] M. D.

5716 221 (Address) St. Joseph 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 Ashland Cemetery DATE OF BURIAL May 17 1927

20. UNDERTAKER Frank J. Rock 406 Sullivan ADDRESS By Tom [Signature]

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.

