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.

1928

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

Do not use this space.

26755

1. PLACE OF DEATH

County: Clark — Registration District No.: 189 — File No.:

Township: Vernon — Primary Registration District No.: 5263 — Registered No.:

City: Alexander (No. ..... St. ..... Ward)

2. FULL NAME Levi Scott

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

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
male	white	single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) [illegible]

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
71	7	12	

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Decatur Ill
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Samuel B Scott

11. BIRTHPLACE OF FATHER (CITY OR TOWN) not known
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Elizabeth Jones

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Penn.
(STATE OR COUNTRY)

14. INFORMANT Mrs Rowy Rose
(Address)

15. FILED 8-13 1928 H. F. Kircher
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8 — 11 1928

17. I HEREBY CERTIFY, That I attended deceased from Aug 11, 1928, to Aug 11 1928 that I last saw him alive on Aug 11, 1928, and that death occurred, on the date stated above, at 5 20 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

dysintery acute

13 C (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Dont Know

..... (duration) ..... yrs. ..... mos. ..... ds.

16

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

DID AN OPERATION PRECEDE DEATH? No. DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Dr. Bebs, M. D

, 19 (Address) Alexandria, 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
Bueno visto	8-13 1928
20. UNDERTAKER	ADDRESS
H F Kircher	Wayland Mo

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Clark — Registration District No. 189 — File No. .....

Township Vernon — Primary Registration District No. 5263 — Registered No. .....

City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME Levi 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 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): S

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 12 – 1857

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
71	7	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

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

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED Aug 11, 1928 F A S Robo
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8 – 11 1928

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19..... that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

..... (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) ....., M. D

, 19 (Address)

*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 — ADDRESS

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES ... THEY ARE COMPLETE AS PRESCRIBED BY LAW

... information should be carefully supplied. AGE ... CTLY. PHYSICIANS should state CAUSE ... in plain terms, so that it may properly clar... of OCCUPATION is very important.

5-26755