

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

Do not use this space.

40085

**PLACE OF DEATH**

County Marion  
Township Marion  
City Hannibal (No. 400 north fourth)

Registration District No. 547  
Primary Registration District No. 3079

File No. \_\_\_\_\_  
Registered No. 370  
St. 3rd Ward

**2. FULL NAME**

Clarence S. Scott

(a) Residence. No. 400 North Fourth 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 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 Maggie Scott

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 30-1869

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
61 3 15

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work Foreman  
(b) General nature of industry, business, or establishment in which employed (or employer) Repair Yard  
(c) Name of employer C. B. & I. Railway

9. BIRTHPLACE (CITY OR TOWN) not known  
(STATE OR COUNTRY) California

10. NAME OF FATHER Thomas Scott

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

12. MAIDEN NAME OF MOTHER Mary Snyder

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) not known  
(STATE OR COUNTRY) Illinois

14. INFORMANT Mrs. Maggie Scott  
(Address) 400 N 4th St. Hannibal, Mo

15. FILED Dec 18 1923 Colossus  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) December 15, 1920

17. I HEREBY CERTIFY, That I attended deceased from January 27, 1920 to Dec 15, 1920, 1920 that I last saw h.l.m. alive on Dec 15, 1920, and that death occurred, on the date stated above, at 11:05 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
myo-carditis  
730

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Dropsy  
(duration) 6 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED  
not at place of death

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) J. C. Chilton, M. D.  
19 (Address) 500 Broadway, Hannibal, 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 Mt Olivet DATE OF BURIAL Dec 17, 1920

20. UNDERTAKER Wm M. Smith ADDRESS 902 Broadway Hannibal, Mo.

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.

NOV 20 1923



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