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.

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

Do not use this space.

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1. PLACE OF DEATH

County: Gasconade — Registration District No.: 308 — File No.: 1

Township: Bourbois — Primary Registration District No.: 5476 — Registered No.: 1

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

2. FULL NAME: Octava Banana Scaillin

(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. 50 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)
Female	white	married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Chas E. Scaillin

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): May 25 -11

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	57	7	10	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: House-wife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.: 235

10. Date deceased last worked at this occupation (month and year) .....

11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Red Bird Mo.

FATHER

13. NAME: G. J. Smith

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Leduc Mo

MOTHER

15. MAIDEN NAME: Harriet Schill

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Franklin Co Mo

17. INFORMANT (ADDRESS): Jackson Smith

18. BURIAL, CREMATION, OR REMOVAL

PLACE: Scaillin Cemetery DATE: Jan 7, 19 31

19. UNDERTAKER (ADDRESS): Ned Hyde, Red Bird Mo

20. FILED: Dec 6, 19 31 M. E. Gunyon M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): Jan 6, 19 31

22. I HEREBY CERTIFY, That I attended deceased from May 31, 1928, to Jan 6, 19 31

I last saw h. alive on Jan 6, 19 31 Death is said to have occurred on the date stated above, at 7 45 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Chronic Cerebral Hemorrhage	
131 Chronic Cerebral Hemorrhage	1928
6 hr Chronic " "	1/4/31

Other contributory causes of importance:

Chronic Nephritis	
Wilks Cirrhosis of Liver	1925 to 26

Name of operation ..... Date of .....

What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19 .....

Where did injury occur? ..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) M. E. Gunyon, M. D.

(Address) Red Bird 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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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: Gasconade — Registration District No.: 308 — File No.:
Township: Bourbois — Primary Registration District No.: 3426 — Registered No.: 1
City: (No. , St. Ward)

2. FULL NAME: Octavus B. Scantlin

(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: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): May 15 1873

7. AGE: Years 57 — Months 7 — Days 10 — If LESS than 1 day, hrs. or min.

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 COUNTY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTY)

14. INFORMANT
(Address)

15. FILED June 6, 1931 M. E. Spurgeon M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): June 6 1931

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

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