

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

Do not use this space.

2368

1. PLACE OF DEATH

County St. Louis Registration District No. 668
Township _____ Primary Registration District No. 3032
City Edalia (No. _____) St. _____ Ward _____

File No. _____
Registered No. 4
St. _____ Ward _____

2. FULL NAME

Gilbert K. Scott
(a) Residence, No. 507 East 5 St., 2 Ward. _____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 18 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
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 21-1880
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
81 | 10 | 11
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Printer
(c) Name of employer _____

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

10. NAME OF FATHER J. M. Scott

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

12. MAIDEN NAME OF MOTHER Mary Scott

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

14. INFORMANT Mrs. Elizabeth Scott (Address) Edalia Mo

15. FILED 134 31 REGISTRAR J. S. Love

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 2 1934

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him alive on not for 12 years, and that death occurred, on the date stated above, at 11:20 PM.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Suppose cerebral hemorrhage
of thrombotic
interstitial

18. CONTRIBUTORY (SECONDARY) arteriosclerosis (duration) _____ yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED? _____ (duration) _____ yrs. mos. da.

18. IF NOT AT PLACE OF DEATH? _____

18. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

18. WAS THERE AN AUTOPSY? _____

18. WHAT TEST CONFIRMED DIAGNOSIS? _____ (Signed) Chas. W. Love, M. D.

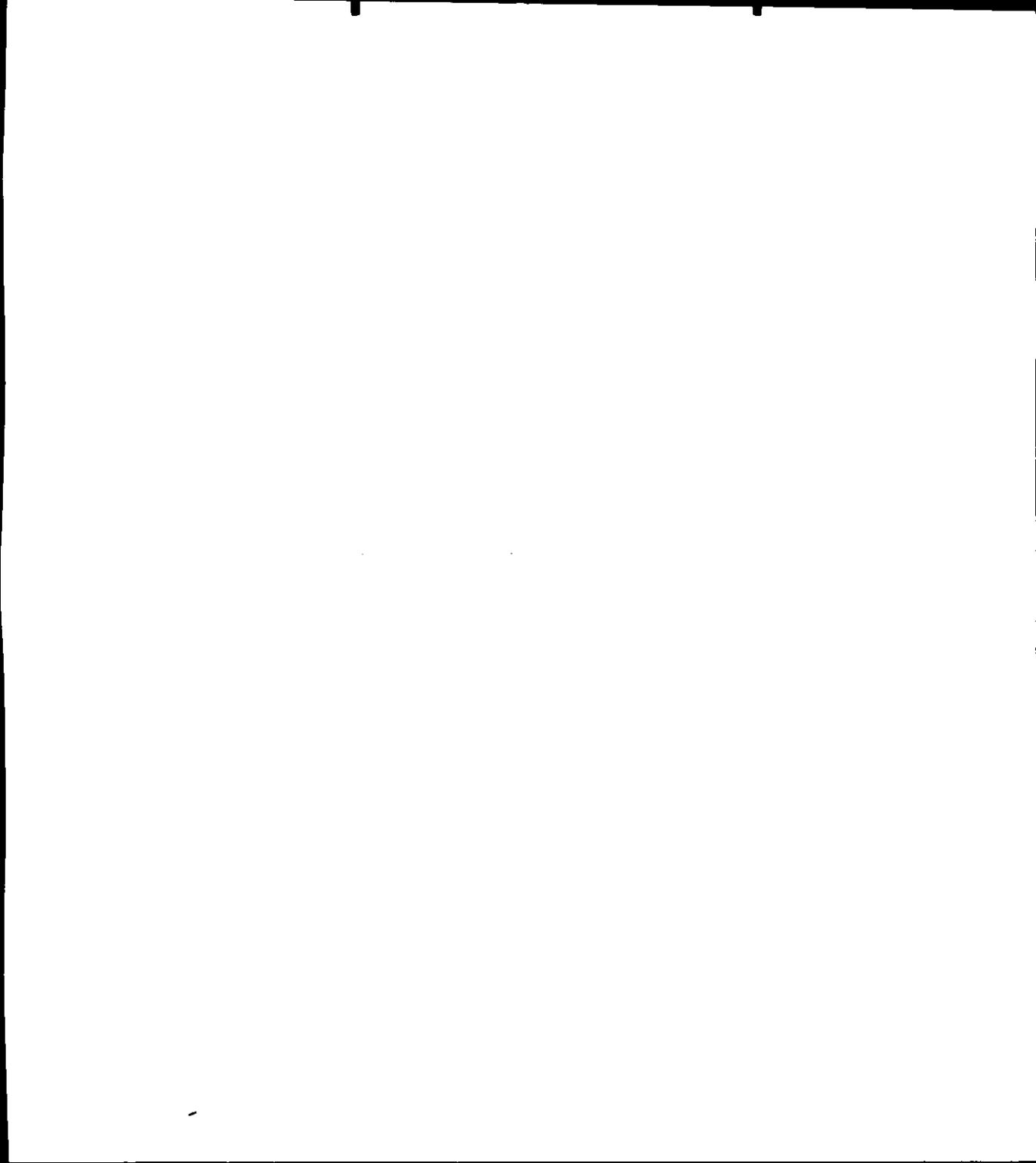
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Edalia Mo DATE OF BURIAL 1/4 1934

20. UNDERTAKER McLaughlin Bros ADDRESS Edalia

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.

80-11-11 FEB 20 1934



**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 Pettis
Township _____
City Sedalia (No. _____)

Registration District No. 668
Primary Registration District No. 3032

File No. _____
Registered No. 4
St. _____ Ward _____

2. FULL NAME

(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) M

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 21 - 1850

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
80 11 11

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)

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 1-3, 1931.

J. J. Love
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 2 1931

17. I HEREBY CERTIFY That I attended deceased from _____, 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:

CONTRIBUTORY (SECONDARY) _____

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

20. UNDERTAKER

ADDRESS

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

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