

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

Do not use this space.

21207

1. PLACE OF DEATH
 County Missouri Registration District No. 576
 Township Lyons Primary Registration District No. 3030
 City Charleston St. _____ Ward _____

2. FULL NAME William Crucian Scofield
 (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 28 yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

File No. _____
 Registered No. 91
 St. _____ Ward _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 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 Mrs. Cary Scofield

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 12 1879

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
54 6 27

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

9. BIRTHPLACE (CITY OR TOWN) Graves County Ky.
 (STATE OR COUNTRY)

10. NAME OF FATHER Thomas Scofield

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

12. MAIDEN NAME OF MOTHER Mary Elizabeth Tate

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

14. INFORMANT Mrs. Corabelle Bagley
 (Address) Charleston Mo.

15. FILED June 29, 1934 F. S. Brown
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 29 1934 1 P.M.

17. I HEREBY CERTIFY, That I attended deceased from 6/27 1934 to 6/29 1934 that I last saw him alive on 6/29 1934 and that death occurred, on the date stated above, at 1:00 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage
32A
102
 (duration) _____ yrs. _____ mos. 3 ds.
 CONTRIBUTORY (SECONDARY) Hypertension
at least (duration) 2 yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED 9121
 IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS? cl. lymph
 (Signed) E. Chastain M. D.
 , 19 _____ (Address) Charleston 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 Oak Grove Cemetery DATE OF BURIAL June 30, 1934

20. UNDERTAKER Frank J. J. Service ADDRESS Charleston 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.

M. S. C. 1081

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