REC'D JUL 7 1938

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

23166

1. PLACE OF DEATH
County: Vernon — Registration District No.: 899 — File No.:
Township: [illegible] — Primary Registration District No.: 6167 — Registered No.:
City: (No. ..... St. ..... Ward)

2. FULL NAME: Susan Catherine Scott — 3[illegible]
(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

SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Widowed

6. IF MARRIED, WIDOWED, ~~OR DIVORCED~~ ~~HUSBAND OR~~ (OR) WIFE OF: Wm W Scott

DATE OF BIRTH (MONTH, DAY AND YEAR): Nov 19-1852

AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	85	-5	9	

OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Hens & Keeper
(b) General nature of industry, business, or establishment in which employed (or employer): Own Home
(c) Name of employer:

BIRTHPLACE (CITY OR TOWN): Indianapolis
(STATE OR COUNTRY): Ind

10. NAME OF FATHER: Fredrick Goings

11. BIRTHPLACE OF FATHER (CITY OR TOWN): None
(STATE OR COUNTRY): Va

12. MAIDEN NAME OF MOTHER: Hannah Hover

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

INFORMANT: Mrs H. M. De Witt
(Address): Stockburg Mo R.F.D.

FILED May 9, 1938 Minnie Renton 79[illegible]
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): April 28 1938

17. I HEREBY CERTIFY, That I attended deceased from Oct 16, 1935, to Apr 28, 1938, that I last saw her alive on Apr 28, 1938, and that death occurred, on the date stated above, at 7:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
Auricular Fibrillation
(duration) 4 yrs. mos. ds.

CONTRIBUTORY (SECONDARY): General Arteriosclerosis
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 93C
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) Laurence L Cooper, M.D.
, 19 (Address) Fort Scott Kns.

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: East Liberty Cemetery — DATE OF BURIAL: April 29 1938

20. UNDERTAKER: Ol Cherry — ADDRESS: Fort Scott Kans.

V. S. No. 2.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

V. S. No. 2.

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BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ...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

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

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

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

7. AGE — YEARS | MONTHS | DAYS | 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 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....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

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

CONTRIBUTORY.....
(SECONDARY)

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

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).....,
, 19 (Address)

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL

20. UNDERTAKER | ADDRESS