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.

REC'D MAR 9 1939

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

5316
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson Registration District No. 399
(b) Township Kaw Primary Registration District No. 1002 Registered No. 515
(c) City Kansas City (d) Street No. 3400 Thompson St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S. if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME William Sampson Scott
(a) Residence, No. 3400 Thompson St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

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 Elizabeth Scott
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 16, 1857
7. AGE YEARS 82 MONTHS 0 DAYS 18 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. Retired
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) Ohio

FATHER
13. NAME David Scott
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

MOTHER
15. MAIDEN NAME Sarah Furhman
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Penn

17. INFORMANT (ADDRESS) Mrs G G Scott 3400 Thompson
18. BURIAL, CREMATION, OR REMOVAL PLACE Mt Mariah DATE Feb 6 1939
19. FUNERAL DIRECTOR (NAME) O N Newcomers Sons (ADDRESS) Brushcreek & Paseo
20. FILED 7 7 1939 M. M. Crowe Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 4 1939
22. I HEREBY CERTIFY, That I attended deceased from Feb 1 1939 to Feb 4 1939
I last saw him alive on Feb 4 1939 Death is said to have occurred on the date stated above, at 8 10 P m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	2/1/39

Other contributory causes of importance: Hypertension & Senility

Name of operation ..... Date of .....
What test confirmed diagnosis? Paralysis 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) Dean S Rising, M. D.
(Address) 1107 Bryant Bldg

Licensed Embalmer's Statement on Reverse Side)

Bryant VI-0848
2:20 5

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ...

....., or by .....

Registered Apprentice No....., working under my personal supervision.

Signed C. Hervey Quisenber

Licensed Embalmer No. 4070

P. O. Address Kansas City,

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.