

RECD MAR 9 1939

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

5329  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Jackson Registration District No. 399  
 (b) Township Law Primary Registration District No. 1002  
 (c) City Kansas City (d) Street No. St Mary Hospital Registered No. 528  
 (e) Length of residence in city or town where death occurred 40 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.  
 2. PRINT FULL NAME Estel Scott  
 (a) Residence, No. Saphian Plaza St.  (Usual place of abode, if no street address, give 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 Lois Scott  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 6, 1877  
 7. AGE YEARS 61 MONTHS 9 DAYS 1 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 11 yrs  
 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) Cooper Co. Missouri  
 FATHER 13. NAME Wm Byron Scott  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri  
 MOTHER 15. MAIDEN NAME unknown  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown  
 17. INFORMANT Mrs Lois Scott (ADDRESS) Saphian Plaza  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Mt Moriah DATE Feb 9 1939  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. Newcomer  
Brusher & Paces  
 20. FILED 1939 M. M. Brown Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 7 1939  
 22. I HEREBY CERTIFY That I attended deceased from 11-30, 1938, to 2-7, 1939  
 I last saw him alive on 2-7, 1939. Death is said to have occurred on the date stated above, at 6:30 A.  
 The principal cause of death and related causes of importance were as follows:  
Pericardial vessel obstruction of pericardium of right kidney, abscess of cortex of kidney  
 Other contributory causes of importance:  
 Date of onset 1175  
 Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis Autopsy Was there an autopsy? yes  
 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? no  
 If so, specify \_\_\_\_\_  
 (Signed) W. P. Miller, M. D.  
 (Address) 800 Argyle

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.

11-30-38

0001-4818  
120-5

**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..... *Neil C. W.*

Licensed Embalmer No. *2976*

P. O. Address *1401 S. ...*

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

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