

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

REC'D APR 17 1939

9593
Do not use this space.

1. PLACE OF DEATH
 (a) County Jackson County Mo. Registration District No. 399
 (b) Township Rear Primary Registration District No. 1002
 (c) City Kansas City Mo. (d) Street No. 5391 Highland Ave. 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 5 yrs. 6 mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Wm. Bion Scott
 (a) Residence, No. 5391 Highland Ave. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 14th 1865

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<u>74</u>		<u>8</u>	<u>3</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None

9. Industry or business in which work was done, as saw mill, bank, etc. _____

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) Flag Springs Mo.

FATHER

13. NAME Wm. Scott

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No RECORD

MOTHER

15. MAIDEN NAME Prudence Smith

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No RECORD

17. INFORMANT (ADDRESS) Sister Camilla 5391 Highland Ave.

18. BURIAL, CREMATION, OR REMOVAL PLACE HEAVEN NORTH, KS DATE Mar. 21, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) ZURK & TOBIN Co. Kansas City Mo.

20. FILED Mar 19 1939 M. M. Brown Local Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 17th 1939

22. I HEREBY CERTIFY, That I attended deceased from August, 1934, to March 17, 1939
 I last saw him alive on March 16, 1939. Death is said to have occurred on the date stated above, at 8 p. m.
 The principal cause of death and related causes of importance were as follows:
Pulmonary tuberculosis (Recurrent) Date of onset 10 years

Other contributory causes of importance: 23

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ 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? _____
 If so, specify _____ (Signed) Paul V. Orourke, M. D.
 (Address) 1462 Brighton Bldg.

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.

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.....

Licensed Embalmer No.....

P. O. Address.....

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.