

REC'D AUG 7 1937

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

24631  
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 295  
 (b) Township Ros Primary Registration District No. 100  
 (c) City Kansas City (d) Street No. 418 West 10 St. 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 20 yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

Registered No. 2814

2. PRINT FULL NAME Mrs. Luddie Mae Scott

(a) Residence, No. 418 West 10 St. 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

3. SEX Female 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 Clyde H. Scott

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) August 22, 1876

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
62 10 20

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month, day, and year) May 21, 1938  
 11. Total time (years) spent in this occupation 17

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) McKinney / Texas

FATHER 13. NAME Edwin Foote /  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) McKinney / Texas

MOTHER 15. MAIDEN NAME Arzelia Harris  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) McKinney / Texas

17. INFORMANT Clyde H. Scott  
 (ADDRESS) 418 West 10 St., K.C. Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Memorial Park DATE 7/15/39 19. \_\_\_\_\_

19. FUNERAL DIRECTOR (NAME) Geo. H. Long  
 (ADDRESS) Kansas City, Kansas

20. FILED July 15, 1937 M. M. Brown  
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 12, 1939

22. I HEREBY CERTIFY, That I attended deceased from 7/9, 1939, to 7/12, 1939  
 I last saw her alive on 7/12, 1939. Death is said to have occurred on the date stated above, at 6:20 P.M.

The principal cause of death and related causes of importance were as follows:  
Chronic Myocarditis Date of onset \_\_\_\_\_  
93c

Other contributory causes of importance:  
Gen Asthenia

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ 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) Chas. S. Long, M. D.  
 (Address) 30 Rue B. B. B.

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.

RECORD

**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,

*Chas. H. Risher*

or by

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

Signed

*Chas. H. Risher*

Licensed Embalmer No.

*3404*

P. O. Address

*Wausau City, Wisc.*

**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.**