

REC'D NOV 7 1939

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

35846  
Do not use this space.

1. PLACE OF DEATH

(a) County Clayton Registration District No. 204  
(b) Township Shoal Primary Registration District No. 3013  
(c) City Cameron (d) Street No. \_\_\_\_\_ St.  
(e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U.S. if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

(a) Residence, No. 540 Clapinda Daniel 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 M 4. COLOR OF RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Ar Daniels  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 2-4-1850  
7. AGE YEARS 89 MONTHS 8 DAYS 18 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired  
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) Scottsville (STATE OR COUNTRY) Ind.

FATHER 13. NAME Reason Scott  
14. BIRTHPLACE (CITY OR TOWN) Ind. (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME Elizabeth Unknown  
16. BIRTHPLACE (CITY OR TOWN) Ind. (STATE OR COUNTRY)

17. INFORMANT Reason McCutchan (ADDRESS) Hamilton Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Delano DATE Oct 24 1939

19. FUNERAL DIRECTOR (NAME) Q. Moore (ADDRESS) Cameron Mo

20. FILED Oct 23 1939 St. Ed. Riley Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 23 1939  
22. I HEREBY CERTIFY, That I attended deceased from 10/17 1939 to 10/21 1939  
I last saw her alive on 10/21 1939. Death is said to have occurred on the date stated above, at 3 A.M.  
The principal cause of death and related causes of importance were as follows:

Cerebral apoplexy  
Chronic hypertensive  
arteriosclerosis

Date of onset 10/17/39  
Unknown

Other contributory causes of importance: 131

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

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) Dr. Bloom D.D. M.D.  
(Address) Cameron, Mo.

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.

1 X14023

HONOLULU DISTRICT EMBALMERS ASSOCIATION

RECEIVED

District No. 118

District File No. 1129-1430

Date Filed NOV 9 1939

**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,

*C. Moore*

or by

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

Signed

*C. Moore*

Licensed Embalmer No.

1180

P. O. Address

*Cameron, Mo.*

**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.**