

Registration District No. 20

Primary Registration District No.

1. PLACE OF DEATH:

(a) County 3
(b) City or town 5861 CATES AVENUE
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
NURSING HOME 5861 CATES AVE
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution FROM OCT 31 - 1939
7 WEEKS (Specify whether years, months or days)

3. (a) PRINT FULL NAME IRA DUDLEY SCOTT 302

8. (b) If veteran, name war unknown 8. (c) Social Security No. NONE

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife CALLEY SOPER SCOTT 6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased Nov. 29 1869
(Month) (Day) (Year)

8. AGE: Years 68 69 Months 11 Days 15 If less than one day hr. min.

9. Birthplace NEVADA MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation DENTIST

11. Industry or business

12. Name WIFE ENERS G SCOTT!

13. Birthplace ILLIS!
(City, town, or county) (State or foreign country)

14. Maiden name JANE BACH

15. Birthplace IND
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Wendell S. Scott

(b) Address 7061 Westwoodland

17. (a) BURIAL (b) Date thereof NOV 16 -39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation BOULDER COLORADO

18. (a) Signature of funeral director C.R. Hupton + Sons

(b) Address NOV 14 2083 DELMAR BLVD.

19. NOV 14 1939 (b) J.F. Brudvik
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1
(c) City or town St. Louis 5
(If outside city or town limits, write "RURAL")
(d) Street No. 5861 Cates
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 14
year 1939 hour 2 minute 30 A.M.

21. I hereby certify that I attended the deceased from Feb. 1, 1939, to Nov. 14, 1939;
that I last saw him alive on Nov. 14, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 1 week
Due to Hypertension 10 yrs.

Due to W

Other conditions W
(Include pregnancy within 3 months of death)

Major findings: Of operations W

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 1

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Wendell S. Scott (M. D. or other)

Address 7061 Westwoodland Date signed 11/14/39

WHILE LIVING - USE OVERLAPPING BLACK INK - MAKE 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.

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 _____

Bradford A. Miles

Licensed Embalmer No. _____

2901

P. O. Address _____

St. Louis, 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.

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

37860
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No. 791
 (b) Township..... Primary Registration District No. 1003
 (c) City..... (d) Street No..... 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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

IRA DUDLEY SCOTT
 (a) Residence, No. 5861 CATES 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

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 11-29-1869

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
69 11 15

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.....
 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).....

FATHER 13. NAME ENERAS G SCOTT

14. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY)..... ILL.

MOTHER 15. MAIDEN NAME JANE BACH

16. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY)..... IND.

17. INFORMANT (ADDRESS).....

18. BURIAL, CREMATION, OR REMOVAL PLACE..... DATE..... 19

19. FUNERAL DIRECTOR (NAME) (ADDRESS).....

20. FILED 12/15/39 19..... J. B. Budick
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR)....., 19.....

22. I HEREBY CERTIFY, That I attended deceased from....., 19....., to....., 19.....
 I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at..... m.
 The principal cause of death and related causes of importance were as follows:

Other contributory causes of importance:
 Date of onset

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?.....
 If so, specify..... (Signed)....., M. D.
 (Address).....

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.