

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

42924

Do not use this space.

JAN 11 1940 9

1. PLACE OF DEATH  
 (a) County Collinsway Registration District No. 104  
 (b) Township Fulton Primary Registration District No. 3008 Registered No. 319  
 (c) City Fulton (d) Street No. State Hosp #1 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. 5 mos. 5 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME John Sconce  
 (a) Residence, No. Miller County St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county only)

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) unknown

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
63 years DK months DK days DK

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. farmer  
 9. Industry or business in which work was done, as saw mill, bank, etc. farmer  
 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) Miller County, Mo.

FATHER  
 13. NAME Jan Sconce

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ray County, Mo.

MOTHER  
 15. MAIDEN NAME (?) Elisewell

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

17. INFORMANT (ADDRESS) State Hosp. #1 - records Fulton Mo.

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE Fulton Mo. DATE Dec 1 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. F. Kendrick J. Weather mo

20. FILED Dec 1 1939 R. N. Crews Local Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-1 1939

22. I HEREBY CERTIFY That I attended deceased from June 26 1939 to Dec 1st 1939  
 I first saw him alive on Nov. 30 1939 Death is said to have occurred on the date stated above, at 6:35 am.  
 The principal cause of death and related causes of importance were as follows:

Bronchopneumonia 11-28-39  
131

Other contributory causes of importance:  
Chronic Renal Vasc. Disease  
hypertension  
Psychosis

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

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? no 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) Geo. F. Wood, M. D.  
 (Address) State Hospital Fulton Mo.

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.**