

Registration District No. _____

Primary Registration District No. 798

WRITE PLAINLY—USE UNFADING 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.

1. PLACE OF DEATH:

(a) County Saline

(b) City or town Rural Blackwater
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: _____

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)

In this community _____ years, months or days

3. (a) PRINT FULL NAME Addie A Scott

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female

5. Color or race white

6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife L. S. Scott

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 24 1859
(Month) (Day) (Year)

8. AGE: Years 80 Months 4 Days 28 If less than one day hr. _____ min.

9. Birthplace Wautoma Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation House Keeper

11. Industry or business _____

MOTHER FATHER

12. Name Ben Hayes

18. Birthplace Council Bluffs Iowa
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Gale

15. Birthplace Council Bluffs Iowa
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Ben Scott

(b) Address Nelson Mo

17. (a) State Cemetery (b) Date thereof Dec 24 1934
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation State Cem - near

18. (a) Signature of funeral director Don Short

(b) Address Marshall Mo 7100

19. (a) Dec 29 1934 (b) E. D. Howell
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 22
year 1934 hour 11:00 A.M. minute _____

21. I hereby certify that I attended the deceased from Dec 14-20
1934 to Dec 22 1934

that I last saw her alive on Dec 20 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 3 days

Due to _____

Due to Hypertension 29

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

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature Marshall (M. D. optional) _____

Address Marshall Mo Date signed _____

MARGIN RESERVED FOR BINDING

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.....

Donald W. Short....., Registered Apprentice No.....
working under my personal supervision.

Signed Donald W. Short.....

Licensed Embalmer No. 3757.....

P. O. Address Marshall, Md.....

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.