

Registration District No. _____

Primary Registration District No. 6223

Registrar's No. 8

1. PLACE OF DEATH:

(a) County Wright
(b) City or town Green Mountain
(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)
In this community 60 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Wright
(c) City or town Green Mt.
(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.

3. (a) PRINT FULL NAME LUCRETIA ARMANDA SCOTT

8. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Wid

6. (b) Name of husband or wife Robert A. Scott 6. (c) Age of husband or wife if alive 22 years

7. Birth date of deceased Dec 31 1954
(Month) (Day) (Year)

8. AGE: Years 85 Months 1 Days _____ If less than one day hr. _____ min. _____

9. Birthplace Marion Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

MOTHER FATHER
12. Name Peter Peubert
18. Birthplace Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Hahnemann
16. Birthplace Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Dr. Beckham
(b) Address Green Mountain Mo

17. (a) Burial (b) Date thereof Feb 2 1948
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Liberty

18. (a) Signature of funeral director James Drapp
(b) Address Mo. Home

19. (a) 2-2-48 (b) Charles Montgomery
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 31
year 1948 hour 3 minute 30 a. M.

21. I hereby certify that I attended the deceased from Jan 12
1948 to Jan 31 1948
that I last saw her alive on Jan 31 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Atherosclerosis

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations _____
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?

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

23. Signature Dr. Beckham (M. D. or other) 1
Date signed Feb 2 1948

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFAADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 6,

District File Number 340-884

Date Filed MAR 15 1940

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 Berge Stapp

Licensed Embalmer No. 3161

P. O. Address W. H. Stapp

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.