

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.

FILED MAY 15 1940

399

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No.

14104

1002

Registrar's No.

1816

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County Jackson  
 (b) City or town Kansas City  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
3912 Park  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 (Specify whether \_\_\_\_\_)  
 In this community 35 Yrs.  
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
 (c) City or town Kansas City  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 3912 Park  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME John Edwin Scott

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3. (b) If veteran, name war no

3. (c) Social Security No. 490-16-8340

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

6. (b) Name of husband or wife Mrs. Maude V. Scott 6. (c) Age of husband or wife if alive 61 years

7. Birth date of deceased Dec. 17, 1866  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>73</u>	<u>4</u>	<u>9</u>	hr. _____ min. _____

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

10. Usual occupation Private Garage Foreman

11. Industry or business \_\_\_\_\_

MOTHER { 12. Name Don't Know

13. Birthplace Don't Know  
 (City, town, or county) (State or foreign country)

14. Maiden name Don't Know

15. Birthplace Don't Know  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Maude V. Scott

(b) Address 3912 Park Avenue

17. (a) Burial (b) Date thereof April 29, 1940  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director Freeman Mortuary

(b) Address 104 W. 42nd St., K.C., Mo.

19. (a) April 29, 1940 (Date received local registrar) M. M. Brown (Registrar's signature)

20. DATE OF DEATH: Month April day 26, year 1940 hour 9 minute 30 A. M.

21. I hereby certify that I attended the deceased from Feb 5<sup>th</sup>, 1940, to April 26, 1940; that I last saw him alive on April 20, 1940 and that death occurred on the date and hour stated above.  
 Immediate cause of death Endocarditis, l.h.v. Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Senility  
 (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 \_\_\_\_\_ ✓

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 J. M. Calmes (M. D. or other) \_\_\_\_\_

Address 3800 1/2 Franklin Date signed 4/26/40

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**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 Clarence H. Chiles

Licensed Embalmer No. 3473

P. O. Address 76 E. 7th St.

**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.**