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NOV 20 1940

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **35961**

Registration District No. **653**

Primary Registration District No. **4390**

Registrar's No. **98**

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

1. PLACE OF DEATH:

(a) County **Pemiscot**

(b) City or town **Hayti**  
(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 **3**  
(Specify whether)

In this community **three weeks**  
(years, months or days)

3. (a) PRINT FULL NAME **Lynn Scott**

8. (b) If veteran, name war **no**

3. (c) Social Security No. **none**

4. Sex **female**

5. Color or race **col.**

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

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive **1905**

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years **35** Months Days If less than one day  
hr. min.

9. Birthplace **Meredian Miss.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **house work**

11. Industry or business **private homes**

12. Name **unknown**

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

14. Maiden name **unknown**

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

16. (a) Informant **letters found in suitcase**

(b) Address

17. (a) **removal** (b) Date thereof **11/4/40**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Meredian Miss.**

18. (a) Signature of funeral director **Ray Funeral Home**

(b) Address **Hayti Mo.**

19. (a) **11-4-40** (b) **Pearl Kelley**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mississippi** (b) County

(c) City or town **Meredian miss**  
(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 **Nov. 2** day  
year **1940** hour **8** minute **30** p.

21. I hereby certify that I attended the deceased from  
\_\_\_\_\_ 19\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death **Heart trouble** Duration

Due to

Due to

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?

**9-4-1**  
While at work? (Specify type of place) (e) Means of injury

28. Signature **Pearl Kelley** Coroner (D. or other) **5**  
Address **Hayti Mo.** Date signed

11-40-74  
8002

**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: John Keller  
Licensed Embalmer No. 3788  
P.O. Address: Hopt. 7th

**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  
STANDARD CERTIFICATE OF DEATH

State File # 35961  
Registrar's No. 98

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 653

Primary Registration District No. 4390

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

ROWENA MCCLARY

1. PLACE OF DEATH:

(a) County Pemisco  
(b) City or town Hayti  
(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 \_\_\_\_\_  
In this community \_\_\_\_\_ (Specify whether years, months or days)

3. (a) PRINT FULL NAME Lynn Seatt

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex ♀ 5. Color bl 6. (a) Single, widowed, married, divorced ♂

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 35 Months Days If less than one day hr. min.

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

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER { 12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (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 Nov day 9 year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_; that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_ and that death occurred on the date and hour stated above. Immediate cause of death Heart trouble duration \_\_\_\_\_

Due to Chronic as history given

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

Other conditions (include pregnancy within 3 months of death) 45 lb

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 Jack Kelly Corcoran (M. D. or other) \_\_\_\_\_

Address Hayti Mo. Date signed 12-13-40

SUPPLEMENTAL

