

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **7662**

Registration District No. **1000274**

Primary Registration District No. **4063**

Registrar's No. _____

1. PLACE OF DEATH: **New. Madrid Co**
 (a) County **New. Madrid Co**
 (b) City or town **Lilbourn MO.**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **Non**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **1**
 (Specify whether _____)
 In this community _____
 years, months or days

8. (a) PRINT FULL NAME **ABE SCOTT Jr.**
 8. (b) If veteran, name war **X**
 3. (c) Social Security No. **X**

4. Sex **M**
 5. Color or race **B**
 6. (a) Single, widowed, married, divorced **0**

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

7. Birth date of deceased **12, 19, 1940**
 (Month) (Day) (Year)

8. AGE: Years _____ Months **2** Days **9**
 If less than one day _____ hr. _____ min.

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

10. Usual occupation **NON**

11. Industry or business **N**

MOTHER FATHER
 { 12. Name: **Abe. Scott**
 { 13. Birthplace: **MISS**
 (City, town, or county) (State or foreign country)
 { 14. Maiden name: **Sister Carl Young**
 { 15. Birthplace: **MO**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Abe Scott**
 (b) Address **Lilbourn Mo**

17. (a) **Burial** (b) Date thereof **3/1 1941**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Sand Hill**

18. (a) Signature of funeral director **S.M. Nell**
 (b) Address **Lilbourn 9110**

19. (a) **3/1/41** (b) **E.E. Jones**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **MO** (b) County **New. Madr**
 (c) City or town **Lilbourn, MO**
 (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.? **0** years.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **2** day **28**
 year **1941** hour **3** a. minute _____ M.

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 _____
 Due to **Encephalitis mother**
N.M.O.

Due to _____
 Other conditions **None**
 (Include pregnancy within 3 months of death)

Major findings: _____
 Of operations _____
 Of autopsy _____
 PHYSICIAN _____

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?
 _____ (Specify type of place)
 537 While at work? _____ (c) Means of injury _____
 23. Signature **E.N. Nelson** (M. D. or other) _____
 Address **Lilbourn Mo** Date signed **2-29-41**

Duration **2 wks**
 Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 2

District File Number 341-337

Date Filed 3/10/46

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

L. Hill

Licensed Embalmer No. 2627

P. O. Address Hilbourn 410

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.