DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 19 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 3339

Registration District No. 743 | Primary Registration District No. 6237 | Registrar's No. 1

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

1. PLACE OF DEATH:

(a) County: RAY

(b) City or town: RURAL - FISHING RIVER
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 4 MILES NORTH OF ORRICK
(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: 19 yrs 3 mons 11 days

2. USUAL RESIDENCE OF DECEASED:

(a) State: MISSOURI (b) County: RAY

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

(d) Street No.: 4 Miles NORTH OF ORRICK
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country: —

3. (a) PRINT FULL NAME: REYBURN SCOTT

3. (b) If veteran, name war: NONE

3. (c) Social Security No.: NONE

4. Sex: MALE

5. Color or race: White

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

6. (b) Name of husband or wife: NONE

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

7. Birth date of deceased: SEPT. (Month) 30 (Day) 1927 (Year)

8. AGE: Years 19 | Months 3 | Days 11 | If less than one day ..... hr. ..... min.

9. Birthplace: RAY COUNTY (City, town, or county) MO (State or foreign country)

10. Usual occupation: MINOR

11. Industry or business: FARMER

FATHER
12. Name: LESTER SCOTT
13. Birthplace: Ray County (City, town, or county) MO (State or foreign country)

MOTHER
14. Maiden name: ROTH HALL
15. Birthplace: RAY COUNTY (City, town, or county) MO (State or foreign country)

16. (a) Informant: MARIE HALL
(b) Address: ORRICK, MO.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: JAN. (Month) 12 (Day) 1941 (Year)
(c) Place: burial or cremation: UNION CEMETERY

18. (a) Signature of funeral director: Gibson & Son Funeral Dir.
(b) Address: Orrick Mo.

19. (a) 1-11-42 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 11 year 1942 hour 1 minute — A.M.

21. I hereby certify that I attended the deceased from Jan 7th 1942, to Jan 11th 1942 that I last saw him alive on Jan 11th 1942 and that death occurred on the date and hour stated above.

Immediate cause of death: Pneumonia — Duration: 7 Days

Due to: Acute Endocarditis —

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

23. Signature: Giffin F. Simmons (M.D. or other) D.O.
Address: ORRICK, MISSOURI Date signed: 1-11-42

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,

District File Number.....

Date Filed 2-17-42

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 Edward C. Gibson

Licensed Embalmer No. 4137

P. O. Address Orrick, Missouri

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

. S. No. 2B
0M—8-21-41
I X29288

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

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MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 3339

Registration District No. 743 Primary Registration District No. 6237 Registrar's No.

1. PLACE OF DEATH:

(a) County Ray

(b) City or town Rural
(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

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) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Reyburn Scott

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Sept (Month) 30 (Day) 1922 (Year)

8. AGE: Years 19 Months 3 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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. Day year 1942 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.

	Duration
Immediate cause of death	
Pneumonia	
Due to Lobar	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations 104	
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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY