

Registration District No. **7**

Primary Registration District No. **3008**

Registrar's No. **141**

1. PLACE OF DEATH:

(a) County **Callaway**  
(b) City or town **London**  
(c) Name of hospital or institution: **State Hospital No. 1**  
(If outside city or town limits, write "RURAL" and name of township)  
(d) Length of stay: In hospital or institution **2 yrs 11 mo 2 d**  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Crocker**  
(c) City or town **Blackwater**  
(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 **Cecelia Scott**

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

4. Sex **Female** 5. Color or Race **Black** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **Scott** 6. (c) Age of husband or wife if alive **Deceased** years \_\_\_\_\_

7. Birth date of deceased: **Feb 22 1859**  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<b>83</b>	<b>7</b>	<b>18</b>	_____ hr. _____ min.

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

10. Usual occupation **Housework**

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

12. Name **Thomas Wilson**

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

14. Maiden name **Oliver**

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

16. (a) Informant **Reard**

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

17. (a) **Burial** (b) Date thereof **5/11/43**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Union Mo**

18. (a) Signature of funeral director **J. J. ...**  
(b) Address \_\_\_\_\_

19. (a) **May 10-43** (b) **Joan Mouschhoff**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **10**  
year **1943** hour **1** minute **0** M.

21. I hereby certify that I attended the deceased from **5/8/1943** to **5/10/1943**  
that I last saw him alive on **5/9/1943**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Acute Myocarditis**  
Due to **Arteriosclerosis**

Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) **9321**

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)  
23. Signature **James H. Keers** (M. D. or other) **MD**  
Address **London Mo** Date signed **5/13/43**

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

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

14  
2

1127

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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.....  
*No. 6 not having*, Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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, fact should be so stated above.**