

AUG 25 1943

Registration District No. 378

Primary Registration District No. 4552

Registrar's No. 36

1. PLACE OF DEATH:

(a) County Wright
(b) City or town Mountain Grove
(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 _____)
In this community 35 yrs years, months or days

3. (a) PRINT FULL NAME Della Scott

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

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced widowed

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

7. Birth date of deceased October 2 1871
(Month) (Day) (Year)

8. AGE: Years 71 Months 9 Days 29 If less than one day _____ hr. _____ min.

9. Birthplace Ontario Canada (City, town, or county) (State or foreign country) 2

10. Usual occupation Housewife

11. Industry or business _____

12. Name Wm Park

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

14. Maiden name Elizabeth Beswetherick

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

16. (a) Informant Lloyd Scott
(b) Address Mtn. Grove

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-1-43 (Month) (Day) (Year)

(c) Place: burial or cremation Hillcrest

18. (a) Signature of funeral director Emmett Barber

(b) Address Mtn. Grove

19. (a) 8-1-43 (Date received local registrar) (b) AmLawe (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Wright
(c) City or town Mountain Grove
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 31 year 1943 hour 4:30 minute 0 A. M.

21. I hereby certify that I attended the deceased from 11-42 to 7/31-1943

that I last saw her alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death chronic arthritis

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 59 lb

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) (e) Means of injury _____

23. Signature R. A. Ryan (M. D. or other) Mtn. Grove
Address _____ Date signed 8-1-43

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

14
1
0

RECEIVED

District Health Officer No. 6,

District File Number 843-941

Date Filed AUG 24 1943

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 Russell Barber

Licensed Embalmer No. 8848

P. O. Address Mt. Hope M

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.