

FILED OCT 13 1943

Registration District No. 49

Primary Registration District No. 1002

Registrar's No. 4009

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City, Mo.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
4216 St. John  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 years (Specify whether years, months or days)

In this community 5 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City, Mo. 3  
(If outside city or town limits, write "RURAL")

(d) Street No. 4216 St John 8  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_ 0

3. (a) PRINT FULL NAME Alexander Scott

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male 5. Color or race W

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

6. (b) Name of husband or wife Vine Scott

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

7. Birth date of deceased March 5, 1859  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>84</u>	<u>6</u>	<u>12</u>	hr. _____ min.

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

10. Usual occupation Retired

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

12. Name Timothy Scott

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

14. Maiden name No Record

15. Birthplace No Record  
(City, town, or county) (State or foreign country)

16. (a) Informant Martin Scott

(b) Address 4216 St. John K.C. Mo.

17. (a) Burial (b) Date thereof Sept. 20-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Washington

18. (a) Signature of funeral director Sheil Funeral Home

(b) Address RE MO

19. (a) 9-19-43 (b) T. E. Brown, Jr  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 17  
year 1943 hour 1 minute 40 P. M.

21. I hereby certify that I attended the deceased from Sept 9, 1943, to Sept 17, 1943  
that I last saw him alive on Sept 19, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Valvular heart disease Duration 20 yrs

Due to Hypertension & myocarditis 20 yrs

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

Other conditions Chronic nephritis 20 yrs  
(include pregnancy, within 3 months of death)

Major findings: None 131/5

Of operations \_\_\_\_\_

Of autopsy None

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

22. If death was due to external causes, fill in the following: no

(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 E. H. Shuster 0 (M. D. or other)

Address 900 Walto Bldg K.C. Mo Date signed 9-18-43

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

MOTHER FATHER

361

Dr. Slusher  
Rialto

VA 2966

**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 J P Shiel  
Licensed Embalmer No. 3625  
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.**