

S. No. 2
M-2-43
-17-39
X35597

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3503

State File No. _____

FILED FEB 9 1944

Registration District No. 200

Primary Registration District No. 3041

Registrar's No. 13

1. PLACE OF DEATH:

(a) County MACON

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

(c) Name of hospital or institution: SAMARITAN HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Month
(Specify whether

In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County MACON 61

(c) City or town RURAL TEN-MILE 3
(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 _____ 0

3. (a) PRINT FULL NAME MALISSA FRANCIS SCOTT

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 22
year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____;
Jan 23 1944
that I last saw her alive on Jan 21, 1944
and that death occurred on the date and hour stated above.

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

(b) Name of husband or wife A. Dudley Scott 6. (c) Age of husband or wife if alive ✓ years

7. Birth date of deceased MAY 8 1867
(Month) (Day) (Year)

Immediate cause of death _____

Due to Broncho Pneumonia

Due to Influenza ✓

Other conditions trying to overcome due to jail
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day

76 7 14 hr. _____ min.

Major findings: Of operations ?

Of autopsy _____

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

9. Birthplace MACON COUNTY Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name James Henry Farmer

13. Birthplace Don't Know
(City, town, or county) (State or foreign country)

14. Maiden name MARGARET ANN

15. Birthplace Don't Know
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Orley Richardson

(b) Address ANABEL

22. If death was due to external causes, fill in the following: ✓ 161

(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? _____

17. (a) BURIAL (b) Date thereof Jan 24 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Tennile - MACON COUNTY

18. (a) Signature of funeral director E. C. Hopper

(b) Address Clarence Mo.

19. (a) 2/4/44 (b) Jora B. Hunkler
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)

23. Signature Frank Roy (M. D. or other) _____
Address Clarence, Mo. Date signed 1/25/44

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

MOTHER FATHER

1051

RECEIVED

District Health Officer No. 10

District File Number 2-44-334

Date Filed FEB 8 1944

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..... *Louis E. Hopper*

Licensed Embalmer No..... *126*

P. O. Address..... *Clarence, Mo.*

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.

Registration District No. 200

Primary Registration District No. 3041

Registrar's No. 13

1. PLACE OF DEATH:

(a) County Macon
 (b) City or town Macon
 (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 _____)
 In this community _____ (Specify whether _____)
 years, months or days

3. (a) PRINT FULL NAME Melissa F Scott

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

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

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

7. Birth date of deceased May 8 (Month) (Day) (Year)

8. AGE: Years 76 Months 7 Days _____ If less than one day _____ min.

9. Birthplace Mo. (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) _____ (b) Date thereof _____ (Month) (Day) (Year)

(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 Branchio Pneumonia

Due to Influenza

Due to injury to cerebellum due to fall

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) Accident

(b) Date of occurrence Dec. 25, 1943

(c) Where did injury occur? Bedroom of Lou Mann, Mo. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Both room stud at home

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

23. Signature Frank K. Roy (M. D. or other) _____

Address _____ Date signed: 2-11-44

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

SUPPLEMENTARY

FILED FEB

3503