DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

11973

FILED MAR 29 1946

State File No.

Registration District No. 352 Primary Registration District No. 4318 Registrar's No.

1. PLACE OF DEATH:

(a) County Taney

(b) City or town Hollister Mo
(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 Seven years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Taney 106

(c) City or town Hollister, Mo 0
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME Monroe Scott

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M 0

5. Color or race W

6. (a) ~~Single~~, widowed, ~~married~~, divorced V

6. (b) Name of husband or wife

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

7. Birth date of deceased Sept (Month) 10 (Day) 1866 (Year)

8. AGE: Years 79 Months 4 Days 26 If less than one day hr. min.

9. Birthplace (City, town, or county) Tenn. (State or foreign country) 1

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name David Scott
13. Birthplace (City, town, or county) Tenn (State or foreign country) 1

MOTHER
14. Maiden name Jane Ford
15. Birthplace (City, town, or county) Tenn (State or foreign country) 1

16. (a) Informant Jack Leathman
(b) Address Hollister Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-6-46 (Month) (Day) (Year)
(c) Place: burial or cremation Enon Ark.

18. (a) Signature of funeral director L.C. Scott
(b) Address Harrison Ark.

19. (a) Feby 6 1946 (Date received local registrar) (b) Archie Brookshire (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 6th
year 1946 hour 5 PM minute M.

21. I hereby certify that I attended the deceased from May, 1949, to Feb 6, 1946;
that I last saw him alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Carcinoma of face	3 yrs
Due to: Carcinoma of lungs	
Due to: Nephritis	1 yr
Chronic Myocarditis	2 yrs
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

23. Signature [illegible] (M. D. or other) D.O.
Address Branson Mo Date signed 2/6/46

525 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6
District File Number 346-246
Date Filed MAR 25 1946

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.....

Licensed Embalmer No.....

P. O. Address.....

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

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. April

Registration District No. 352 Primary Registration District No. 4518 Registrar's No.

1. PLACE OF DEATH:

(a) County Taney

(b) City or town Hollister
(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 years, months or days)

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 Monroe 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 Wid

6. (b) Name of husband or wife

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

7. Birth date of deceased Sept (Month) 10 (Day) 1866 (Year)

8. AGE: Years 79 Months 4 Days 26 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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 Feb day 6
year 1946 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.

Immediate cause of death

Due to Carcinoma of Lower gum (Right)

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy 45d

Duration

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature [signature] (M.D. or other)

Address Bronson Date signed 4/6/46

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

10884

11973