

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
FILED JUL 16 1946 STANDARD CERTIFICATE OF DEATH

23796
State File No. _____
Registrar's No. **2951**

Registration District No. 149 Primary Registration District No. 1002

1. PLACE OF DEATH:
(a) County KANSAS
(b) City or town KANSAS CITY
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: RESEARCH HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 20-DAYS
(Specify whether years, months or days) 20 days

3. (a) PRINT FULL NAME GERALD POUND SCOTT
3. (b) If veteran, name war No
3. (c) Social Security No. 509-10-5455

4. Sex MALE **5. Color or race** WHITE
6. (a) Single, widowed, (married, divorced, MARRIED
6. (b) Name of husband or wife Mrs. VURVA HUCKSTAR SCOTT
6. (c) Age of husband or wife if alive 31 years
7. Birth date of deceased July 10 1915
(Month) (Day) (Year)

8. AGE: Years 30 Months 11 Days 25
If less than one day hr. _____ min. _____

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

10. Usual occupation Police Officer

11. Industry or business GARDEN CITY, KANSAS

12. Name Edward H. Scott

13. Birthplace Garfield Kansas
(City, town or county) (State or foreign country)

14. Maiden name Alma Pound

15. Birthplace Clarksdale Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Vurva Huckstar Scott

(b) Address GARDEN CITY, KANSAS

17. (a) BURIAL (Burial, cremation, or removal) BURIAL
(b) Date thereof JULY 5 1946
(Month) (Day) (Year)

(c) Place: burial or cremation GARDEN CITY, KANSAS

18. (a) Signature of funeral director W. H. Newcomer, Inc.
(b) Address 1401 BRUSH CREEK BLVD

19. (a) 7-5-46 (Date received local registrar)
(b) Geraldine Holman (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Kansas (b) County Finner
(c) City or town Garden City
(If outside city or town limits, write "RURAL")
(d) Street No. 1112 No 12th STREET
(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 5TH
year 1946 hour 05 minute 02 M.

21. I hereby certify that I attended the deceased from June 12 1946 to July 5 1946
that I last saw him alive on _____, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Went to General Hospital ch.
Pharynx
Due to _____
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy Yes - 13/15

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)
Means of injury _____

23. Signature [Signature] (M. D. or other)
Address 1207 W **Date signed** 7/5/46

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

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

22652

SEP 12 1947

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 Emile M. Calhoun
Licensed Embalmer No. 3506
P. O. Address K.C. 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.