

Primary Registration District No. 5081

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

1. PLACE OF DEATH:

(a) County Bates
 (b) City or town Archie Rural
(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 670 yrs.
years, months or days

3. (a) PRINT FULL NAME William Le Roy Scott
 3. (b) If veteran, name war no
 3. (c) Social Security No. none

4. Sex M 5. Color or race W.
 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife Una Scott
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased 2-13-1877
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>70</u>	<u>0</u>	<u>10</u>	hr. _____ min. _____

9. Birthplace Burdett, Bates Co mo
(City, town, or county) (State or foreign country)

10. Usual occupation farmer

11. Industry or business _____

MOTHER FATHER

12. Name Edward Scott
 13. Birthplace Ill.
 14. Maiden name Frances Edwards
 15. Birthplace Ill.

16. (a) Informant Mrs Una Scott

(b) Address Archie MO

17. (a) Burial **(b) Date thereof** 2-26-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Burial Sharonland

18. (a) Signature of funeral director Archie
(b) Address Archie MO

19. (a) 2-25-47 **(b)** Nysa Owens
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Bates
 (c) City or town Archie Rural
(If outside city or town limits, write "RURAL")
 (d) Street No. East Rome Township
(If rural, give location)
 (e) Citizen of foreign country? NO (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 23rd
 year 1947 hour 4 minute 15 P.M.

21. I hereby certify that I attended the deceased from Jan 20
1947, to Feb 23 1947
 that I last saw him alive on Feb 22 1947
 and that death occurred on the date and hour stated above.

Immediate cause of death Crown
aneurysm

Due to arteriosclerosis

Due to _____

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

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 Danny O'Keefe (M. D. or other) _____
 Address Garfield, Mo Date signed 2-24-47

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

RECEIVED
District Health Officer No. 7,
District No. 2-47-180
Date Filed 3-3-47

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, ~~only~~.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed Lloyd Atkinson
Licensed Embalmer No. 3920
P. O. Address Harrisonville

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.