

8. No. 2
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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33920**

FILED NOV 3 1947

Registration District No. **59**

Primary Registration District No. **4097**

Registrar's No. **163**

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

1. PLACE OF DEATH:

(a) County **Cass**
(b) City or town **Harrisonville**
(c) Name of hospital or institution: **403 East Pearl St**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **5 years**
In this community **5 years**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **EMMA M. SCOTT**

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

4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Widowed**

(b) Name of husband or wife **J. E. Scott** 6. (c) Age of husband or wife if alive **21** years

7. Birth date of deceased **May 21 1874**
(Month) (Day) (Year)

8. AGE: Years **73** Months **5** Days **6**
If less than one day hr. min.

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

10. Usual occupation **House-wife**

11. Industry or business

MOTHER FATHER

12. Name **Joel Parker**

13. Birthplace **Illinois**
(City, town, or county) (State or foreign country)

14. Maiden name **Martha Sinclair**

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

16. (a) Informant **Ruth Liberman**

(b) Address **Kreman Mo.**

17. (a) **Burial** (b) Date thereof **Oct 30-1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Sharon Cemetery**

18. (a) Signature of funeral director **RUNNENBURGER'S**
(b) Address **HARRISONVILLE, MO.**

19. (a) **Oct. 29-1947** (b) **Laura J. Jones**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Cass** 19
(c) City or town **Harrisonville**
(If outside city or town limits, write "RURAL")
(d) Street No. **403 East Pearl St**
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) **0**
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **27**
year **1947** hour **4:15** minute **P** M.

21. I hereby certify that I attended the deceased from **Aug 1946**
to **Oct 20 1947**
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Thrombosis**
Duration

Due to **Rheumatic Heart Disease 40 YRS.**

Due to **AB**

Other conditions: **AB**
(Include pregnancy within 3 months of death)

Major findings:
Of operations **AB**
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)
(b) Date of occurrence

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 **0**

23. Signature **J. J. Jones** (M. D. **MD**)

Address **Harrisonville Mo** Date signed **10-29-47**

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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. 33768

P. O. Address Harrisonville, 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.