

1. PLACE OF DEATH: **Vernon**  
(a) County  
(b) City or town **Rural, Washington Township**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **State Hospital, #3**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **7 mos. 7 days**  
In this community **7 months, 7 days** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Martin E. Scott**  
3. (b) If veteran, name war **--** 3. (c) Social Security No. **--**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced, widowed **2 divorced Widowed**  
6. (b) Name of husband or wife **--** 6. (c) Age of husband or wife if alive **--** years  
7. Birth date of deceased **June 27 1869**  
(Month) (Day) (Year)

8. AGE: Years **78** Months **4** Days **14** If less than one day **hr. min.**

9. Birthplace **Novascotia**  
(City, town, or county) (State or foreign country) **2**

10. Usual occupation **Janitor**

11. Industry or business **--**  
12. Name **Timothy Scott**  
13. Birthplace **Unknown**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Isabel Bachrick**  
15. Birthplace **Unknown**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Hospital Record**  
(b) Address **Nevada, Mo.**

17. (a) **Removal** (b) Date thereof **II-10-47**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Kansas City, Mo.**

18. (a) Signature of funeral director **Sheil Funeral Home**  
(b) Address **Kansas City, Missouri**

19. (a) **11-19-47** (b) **Kathryn Yancy**  
(Date received local registrar) (Registrar's signature) **2311**

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **Jackson**  
(c) City or town **Kansas City**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **4317 E. 39th**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? **No.** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **9th**  
year **1947** hour **8** minute **35 P.M.**  
21. I hereby certify that I attended the deceased from **Apr. 2**, 19 **47** to **Nov. 9**, 19 **47**;  
that I last saw him alive on **Nov. 9**, 19 **47**;  
and that death occurred on the date and hour stated above.

Immediate cause of death **Arteriosclerosis**

Due to **--**  
Due to **--**

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

Major findings: Of operations **--**  
Of autopsy **No**

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 **R. H. Hall** (M.D. or other)  
Address **Nevada Mo** Date signed **11-12-47**

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

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

RECEIVED  
District Health Officer No. 7,  
District File Number 10-47-1343  
Date Filed 11-24-43

**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 Mark Eichinger  
Licensed Embalmer No. 2656  
P. O. Address Nevada, 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, above space should be left blank.**