

FILED MAR 11 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 3926

BIRTH NO. _____		REG. DIST. NO. 1		PRIMARY REG. DIST. NO. 4002		Registrar's No. 64	
1. PLACE OF DEATH a. COUNTY <b>ADAIR</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY <b>ADAIR</b>			
b. CITY OR TOWN <b>BRASHEAR</b>		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN <b>BRASHEAR</b>		d. STREET ADDRESS (If rural, give location) <b>NONE</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>NONE</b>				d. STREET ADDRESS (If rural, give location) <b>NONE</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>MABEL</b>		b. (Middle) <b>PEARL</b>		c. (Last) <b>SCOTT</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>JAN 26 1949</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>AUG. 14, 1892</b>	9. AGE (In years last birthday) <b>56</b>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>ADAIR CO - MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY? <b>NO</b>	
13a. FATHER'S NAME <b>WILLIAM BALDWIN</b>		13b. MOTHER'S MAIDEN NAME <b>RETTIE (UNKNOWN)</b>		14. NAME OF HUSBAND OR WIFE <b>HARLEN SCOTT</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT'S SIGNATURE OR NAME <b>HARLEN SCOTT</b> ADDRESS <b>BRASHEAR MO</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cor acute heart attack</b>  ANTECEDENT CAUSES DUE TO (b) <b>Diabetes Mellitus</b> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <b>Loss leg</b> DUE TO (c) <b>Had gangrenous leg amputated.</b>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>  <b>4 yr</b>  <b>18 months before death</b>
19a. DATE OF OPERATION <b>1 1/2 yrs before death</b>		19b. MAJOR FINDINGS OF OPERATION <b>Amputated leg</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>Shot</b>					
22. I hereby certify that I attended the deceased from <b>Sept</b> , 1947, to <b>Jan</b> , 1949, that I last saw the deceased alive on <b>Jan 26</b> , 1949 and that death occurred at <b>12</b> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>H. M. Humphrey M.D.</b>				23b. ADDRESS <b>Brashear Mo</b>		23c. DATE SIGNED <b>2-26-49</b>	
24a. BURIAL, CREMATION REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>JAN 29, 1949</b>	24c. NAME OF CEMETERY OR CREMATORY <b>BRASHEAR</b>		24d. LOCATION (City, town, or county) (State) <b>BRASHEAR MO</b>		
DATE REC'D BY LOCAL REG. <b>2-28-49</b>		REGISTRAR'S SIGNATURE <b>Rita Lambert</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Pat R. Eady</b> ADDRESS <b>Brashear Mo</b>			

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED  
District Health Officer  
District File No. S. 49. 4444  
MAR 10 1949

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed Geo B. Easley

Licensed Embalmer No. 3755

P. O. Address Studdard 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.