

FILED APR 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

7618

State File No.

 BIRTH NO. 1400 REG. DIST. NO. 389 PRIMARY REG. DIST. NO. 5165 Registrar's No. 7

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Callaway</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Callaway</u> | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Guthrie</u> | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Guthrie</u> | |
| c. LENGTH OF STAY (In this place) <u>wife</u> | | 14 0 0 | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Guthrie Hosp 1</u> | | d. STREET ADDRESS (If rural, give location) <u>11 0</u> | |

| | | | | | |
|--|--|--|---|--|--|
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Margaline</u> b. (Middle) <u>Scott</u> c. (Last) <u>Scott</u> | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>April 8-1949</u> | | |
|--|--|--|---|--|--|

| | | | | | | |
|----------------------|-------------------------------|---|-------------------------------------|---|---------------------------|----------------------------|
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>NEVER MARRIED</u> | 8. DATE OF BIRTH <u>July 6 1880</u> | 9. AGE (In years last birthday) <u>68</u> | 10. UNDER 1 YEAR <u>9</u> | 11. UNDER 10 HRS. <u>6</u> |
|----------------------|-------------------------------|---|-------------------------------------|---|---------------------------|----------------------------|

| | | | |
|---|-----------------------------------|---|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) <u>Callaway County Mo</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
|---|-----------------------------------|---|--|

| | | |
|--|---|-----------------------------|
| 13a. FATHER'S NAME <u>William King</u> | 13b. MOTHER'S MAIDEN NAME <u>Liza Scott</u> | 14. NAME OF HUSBAND OR WIFE |
|--|---|-----------------------------|

| | | | |
|---|-----------------------------------|--|---------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | 16. SOCIAL SECURITY NO. <u>No</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>John Duelle</u> | ADDRESS <u>Guthrie Mo</u> |
|---|-----------------------------------|--|---------------------------|

| | | | |
|---|---|--|--|
| 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, asthenia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH <u>Two weeks</u> |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u> | | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>351X</u> DUE TO (c) | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>General Arteriosclerosis</u> | | | |

| | | |
|------------------------|----------------------------------|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 (Month) (Day) (Year) (Hour) OF INJURY | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |
|---|--|----------------------------|

22. I hereby certify that I attended the deceased from April 1, 1949, to April 8, 1949, that I last saw the deceased alive on Mar 25, 1949, and that death occurred at 11-45 AM., from the causes and on the date stated above.

| | | |
|---|---------------------------------------|--------------------------------------|
| 23a. SIGNATURE <u>D. W. Rusk MD</u> (Degree or title) | 23b. ADDRESS <u>New Bloomfield Mo</u> | 23c. DATE SIGNED <u>April 8 1949</u> |
|---|---------------------------------------|--------------------------------------|

| | | | |
|---|----------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>APR-10-49</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Oak Chapel</u> | 24d. LOCATION (City, town, or county) (State) <u>3 mi West Guthrie Mo</u> |
|---|----------------------------|--|---|

| | | | |
|--|---|---|-----------------------------|
| DATE REC'D BY LOCAL REG. <u>Apr-8-49</u> | REGISTRAR'S SIGNATURE <u>LeRoy Claypool</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Holt-Claypool</u> | ADDRESS <u>Sec. N.E. Mo</u> |
|--|---|---|-----------------------------|

(Licensed Embalmer's Statement on Reverse Side)

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

 No. 300
10.48

APR 13 1949

RECEIVED
District Health Officer No. 9,

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.

Signed _____
Student Embalmer

Signed

LeRoy C. Cuyper

Licensed Embalmer No. 4412

P. O. Address

New Bloomfield

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.