

FILED MAR 26 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **8598**  
**951**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. \_\_\_\_\_

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Jackson</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Mo.</b> b. COUNTY <b>Jackson</b> <u>4A</u> |   |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Kansas City</b> <u>11</u> | c. LENGTH OF STAY (in this place) <b>34 Days</b> | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Kansas City</b>  | d. STREET ADDRESS (If rural, give location) <b>1220 W. 58th St.</b> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Lukes Hospital</b>   |  |  |   |

|   |                       |                           |  |
|---|-----------------------|---------------------------|--|
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <b>Arthur</b> | b. (Middle) <b>D.</b> | c. (Last) <b>Scarritt</b> | 4. DATE OF DEATH (Month) (Day) (Year) <b>2-27-49</b> |
|---|-----------------------|---------------------------|--|

|                 |                           |   |                                   |   |  |   |
|-----------------|---------------------------|---|-----------------------------------|---|--|---|
| 5. SEX <b>M</b> | 6. COLOR OR RACE <b>W</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b> | 8. DATE OF BIRTH <b>5-11-1895</b> | 9. AGE (In years last birthday) <b>53</b> | IF UNDER 1 YEAR Months <b>2</b> Days <b>10</b> | IF UNDER 24 HRS. Hours <b></b> Min. <b></b> |
|-----------------|---------------------------|---|-----------------------------------|---|--|---|

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

|   |                                    |  |
|---|------------------------------------|--|
| 13a. FATHER'S NAME <b>William C. Scarritt</b> | 13b. MOTHER'S MAIDEN NAME <b>?</b> | 14. NAME OF HUSBAND OR WIFE <b>Anna W. Scarritt.</b> |
|---|------------------------------------|--|

|  |                                   |   |                                 |
|--|-----------------------------------|---|---------------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>WW#1</b> | 16. SOCIAL SECURITY NO. <b>No</b> | 17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Anna Scarritt</b> | ADDRESS <b>1220 W. 58th St.</b> |
|--|-----------------------------------|---|---------------------------------|

|   |   |              |                                  |
|---|---|--------------|----------------------------------|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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   |              | INTERVAL BETWEEN ONSET AND DEATH |
|   | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Generalized sarcomatosis</b>  |              | <b>6 Mo.</b>                     |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <b>Myxosarcoma of scalp</b><br>DUE TO (c) <b>recurrence of arterio-</b> |              | <b>12 Mo.</b>                    |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <b>sign to brain - Lt parietal area</b>   |   | <b>8 Mo.</b> |                                  |

|                                      |  |  |
|--------------------------------------|--|--|
| 19a. DATE OF OPERATION <b>7/8/48</b> | 19b. MAJOR FINDINGS OF OPERATION <b>Brain tumor - (see above) Excision</b> | 20. AUTOPSY? YES <input checked="" 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) | 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 10/11, 1945, to 2/27, 1949, that I last saw the deceased alive on 2/27, 1949, and that death occurred at 6:10 P m., from the causes and on the date stated above.

|   |  |                                 |
|---|--|---------------------------------|
| 23a. SIGNATURE <b>J. Q. Chambers, Jr.</b> (Degree or title) <b>M.D.</b> | 23b. ADDRESS <b>1103 Grand Ave; K.C.</b> | 23c. DATE SIGNED <b>2/28/49</b> |
|---|--|---------------------------------|

|   |                         |   |  |
|---|-------------------------|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> | 24b. DATE <b>3/2/49</b> | 24c. NAME OF CEMETERY OR CREMATORY <b>Wm Washington</b> | 24d. LOCATION (City, town, or county) (State) <b>K. C. Mo.</b> |
|---|-------------------------|---|--|

|  |   |   |                                 |
|--|---|---|---------------------------------|
| DATE REC'D BY LOCAL REG. <b>3-1-49</b> | REGISTRAR'S SIGNATURE <b>Geraldine Holmes</b> | 25. FUNERAL DIRECTOR'S SIGNATURE <b>STINE &amp; McCLURE</b> | ADDRESS <b>Kansas City, Mo.</b> |
|--|---|---|---------------------------------|

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

*Prof. Bledy*

**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 \_\_\_\_\_

*Max E. Meyer*

Signed \_\_\_\_\_

Student Embalmer

Licensed Embalmer No. \_\_\_\_\_

*4555*

P. O. Address \_\_\_\_\_

*Kansas City, 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.