

FILED FEB 16 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5137

No. 300
10. 48

BIRTH NO. _____ REG. DIST. NO. 154 PRIMARY REG. DIST. NO. 5575 Registrar's No. 3

1. PLACE OF DEATH
a. COUNTY Jackson

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Missouri b. COUNTY Jackson

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural, Washington

c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Hickman Mills 0480

d. FULL NAME OF HOSPITAL OR INSTITUTION 3 1/2 mi. S.E. Grandview

d. STREET ADDRESS (If rural, give location) none 0

3. NAME OF DECEASED (Type or Print)
a. (First) Olive b. (Middle) c. (Last) Scott

4. DATE OF DEATH (Month) (Day) (Year)
Feb. 10, 1950

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH Sept. 23, 1864

9. AGE (In years last birthday) 85 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home

10b. KIND OF BUSINESS OR INDUSTRY own home

11. BIRTHPLACE (State or foreign country) Illinois

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Jacob Swaney

13b. MOTHER'S MAIDEN NAME Lydia Gault

14. NAME OF HUSBAND OR WIFE Chas. M. Scott

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no

16. SOCIAL SECURITY NO. none

17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. E. L. Young, Grandview, Mo.

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, asthma, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) myocardial degeneration
ANTECEDENT CAUSES
DUE TO (b) Semblity
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last:
DUE TO (c)
II. OTHER SIGNIFICANT CONDITIONS: Fractured hip about 8 yrs. ago which failed to heal and kept her bedfast.

INTERVAL BETWEEN ONSET AND DEATH

4222
20. AUTOPSY? YES NO

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

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 NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March, 1941, to Feb 10, 1950, that I last saw the deceased alive on Jan 20, 1950, and that death occurred at 1:15 PM, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Annie S. Hodges D.O.

23b. ADDRESS Hickman Mills, Mo.

23c. DATE SIGNED 2/10/50

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 2/11/50

24c. NAME OF CEMETERY OR CREMATORY Mt. Moriah

24d. LOCATION (City, town, or county) (State) Hickman Mills, Mo.

DATE REC'D BY LOCAL REG. 2/10/50

REGISTRAR'S SIGNATURE Dr. Annie S. Hodges

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS B. K. Seay, 4 Ave, Grandview Mo.

(Licensed Embalmer's Statement on Reverse Side)

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

FEB 14 RECD

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

A. K. George

Licensed Embalmer No. *3645*

P. O. Address. *Grandview 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.