

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

RECEIVED
State File No. 4145
REGISTRAR'S NAME

FILED MAR 5 1952

BIRTH NO. _____ REG. DIST. NO. 43 PRIMARY REG. DIST. NO. 4057

1. PLACE OF DEATH a. COUNTY Butler		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Butler	
b. CITY (If outside corporate limits, write RURAL and give township) Qulin		c. CITY (If outside corporate limits, write RURAL and give township) Qulin	
c. LENGTH OF STAY (in this place) 35 yrs		d. STREET ADDRESS (If rural, give location) City	
d. FULL NAME OF HOSPITAL OR INSTITUTION Home City			

3. NAME OF DECEASED (Type or Print)	a. (First) LOLA	b. (Middle) EMMA	c. (Last) SCOTT	4. DATE OF DEATH (Month) (Day) (Year) FEB. 19 1952
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5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify). Widowed	8. DATE OF BIRTH June 28, 1880	9. AGE (In years last birthday) Months Days 71 7 21	IF UNDER 1 YEAR Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (State or foreign country) Illinois	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE ---
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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. unknown	17. INFORMANT'S SIGNATURE OR NAME Bessie Scott, Cardwell, Missouri	ADDRESS
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____		
	DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 331X	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., to or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Feb. 19, 1952**, to **Feb. 19, 1952**, that I last saw the deceased alive on **2/19**, 19**52**, and that death occurred at **1:30 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE H. J. Rutledge, M.D.	(Degree or title)	23b. ADDRESS Campbell, Mo.	23c. DATE SIGNED 2/22/52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Feb. 21, 1952	24c. NAME OF CEMETERY OR CREMATORY Vincent Cemetery	24d. LOCATION (City, town, or county) (State) Campbell, Missouri R.1
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DATE REC'D BY LOCAL REG. Feb. 22, 1952	REGISTRAR'S SIGNATURE Wm. H. Johnson	428-0	25. FUNERAL DIRECTOR'S SIGNATURE Landess Funeral Home	ADDRESS Campbell, Mo
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(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
MAR 4 - 1952
BUTLER CO. HEALTH CENTER
FILE No. 352-116

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 Christina M. Landess

Licensed Embalmer No. 4227

P. O. Address Campbell, 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.