

FILED JUN 3 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16156

State File No. 2244

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

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Kansas</u> b. COUNTY <u>Miami</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Oswatimie</u>	
c. LENGTH OF STAY (If this place) <u>4 days</u>		8/15-0 9	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Marys</u>		d. STREET ADDRESS (If rural, give location) <u>228 Main</u>	

3. NAME OF DECEASED (Type or Print) <u>PRESSLEY ROSCOE SCOTT</u>	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) <u>MAY. 17 - 1954</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 16 - 1879</u>	9. AGE (In years last birthday) <u>74</u>	10. UNDER 1 YEAR Months	11. UNDER 2 HRS. Hours	12. IF UNDER 2 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	11. BIRTHPLACE (State or foreign country) <u>Indiana</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
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13. FATHER'S NAME <u>Joseph Scott</u>	13b. MOTHER'S MAIDEN NAME <u>Matilda Stowers</u>	14. NAME OF HUSBAND OR WIFE <u>Ellis Scott</u>
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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) <u>No.</u>	16. SOCIAL SECURITY NO. <u>-</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mr. P. R. Scott</u>	ADDRESS <u>Oswatimie, Mo.</u>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 443X
	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u> of day		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertensive Cardiovascular Disease</u> 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	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., in 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) (Min.)	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 5-13, 1954, to 5-17, 1954, that I last saw the deceased alive on 5-16, 1954, and that death occurred at 3:55 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>J. E. Castle</u>	(Degree or title) <u>M.D.</u>	23b. ADDRESS <u>1002 Argyle Bldg. Kansas City, Mo.</u>	23c. DATE SIGNED <u>5-17-54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>5-17-54</u>	24c. NAME OF CEMETERY OR CREMATOR <u>-</u>	24d. LOCATION (City, town, or county) (State) <u>Oswatimie, Kansas</u>
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DATE REC'D BY LOCAL REG. <u>5-18-54</u>	REGISTRAR'S SIGNATURE <u>Steraldine Smith</u>	EMERAL DIRECTOR'S SIGNATURE <u>William H. Eddy</u>	ADDRESS <u>Oswatimie, Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

JUN 3 1991

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 Removed to Ossawatimie Kans, Student Embalmer No. _____
working under my personal supervision.

Student
Student Embalmer

Signed Wm Eddy _____

Licensed Embalmer No. _____

P. O. Address _____

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.