

FILED DEC 27 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **41202**  
**5470**

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		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>Missouri</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u>		c. LENGTH OF STAY (in this place) <u>16 days</u>		c. CITY OR TOWN <u>Grandview</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St Marys Hosp</u>				e. STREET ADDRESS (If rural, give location) <u>12907 10th Street</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Virgil</u> b. (Middle) <u>William</u> c. (Last) <u>SCOTT</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>11-25-54</u>				
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>June 17, 1919</u>	
9. AGE (In years last birthday) <u>35</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 HR. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Hestinghouse</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Aurora Nebraska</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Geo. M. Scott</u>			13b. MOTHER'S MAIDEN NAME <u>Effie Logue</u>		14. NAME OF HUSBAND OR WIFE <u>Arlene Scott</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>482 07 4997</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Arlene Scott, Grandview Mo.</u> ADDRESS <u>Mo.</u>			
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Embolus</u>					<u>Hours</u>
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES					<u>Months</u>
		DUE TO (b) <u>Auricular Thrombus</u>					<u>Months</u>
		DUE TO (c) <u>Auricular Fibrillation</u> <u>Mitral Regurg</u> <u>Mitral Stenosis</u> <u>Rheum. HD</u>					<u>Yrs</u>
		II. OTHER SIGNIFICANT CONDITIONS					<u>Yrs</u>
		Conditions contributing to the death but not related to the disease or condition causing death. <u>CHRONIC Hepatitis</u>					<u>Yrs</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 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 <u>11-10, 1954</u> , to <u>11-25, 1954</u> , that I last saw the deceased alive on <u>11-25, 1954</u> , and that death occurred at <u>10:20 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>V. B. Ballard</u> (Degree or title) <u>MD</u>				23b. ADDRESS <u>411 Nichols Road</u> <u>Kansas City 12 Mo</u>		23c. DATE SIGNED <u>11-26-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>11/27/54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Rose Niece Cem</u>		24d. LOCATION (City, town, or county) (State) <u>Not in Iowa</u>	
DATE REC'D BY LOCAL REG. <u>11-27-54</u>		REGISTRAR'S SIGNATURE <u>neva minshall</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Ed George &amp; Sons Inc</u> ADDRESS <u>Grandview</u>			

(Licensed Embalmer's Statement on Reverse Side) By Stoddard Mo.

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

**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.....  
Signature of Student Embalmer

Signed.....  
*Sterling E. Goddard*

Licensed Embalmer No..... *491*

P. O. Address.....  
*Grandville*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.