

FILED SEP 22 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **29904**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **146** PRIMARY REG. DIST. NO. **3026** Registrar's No. **346**

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Independence</b>	c. LENGTH OF STAY (In this place) <b>32yrs</b>	c. CITY OR TOWN <b>Independence</b>	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 <b>1208 E. Truman Rd.</b>		f. STREET ADDRESS (If rural, give location) <b>1208 E. Truman Rd. 9005</b>	

3. NAME OF DECEASED (Type or Print) <b>MRS. CATHERINE J. SCANTLIN</b>	a. (First) <b>J.</b> b. (Middle) <b>SCANTLIN</b> c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) <b>Sept. 14, 1955</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Divorced</b>	8. DATE OF BIRTH <b>Oct. 26, 1880</b>	9. AGE (In years last birthday) <b>74</b>	IF UNDER 1 YEAR Months Days	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) <b>At Home</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>Lacone, Iowa.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Albert Smith</b>	13b. MOTHER'S MAIDEN NAME <b>Sarah Ann Smith</b>	14. NAME OF HUSBAND OR WIFE <b>Lewis Scantlin</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give year or dates of service)	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Theora Bornaman</b>	ADDRESS <b>Indep, Mo/</b>
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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 <b>1 week</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Broncho-pneumonia</b>		<b>9040</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>fractured hip</b> DUE TO (c) <b>fall in her home &amp; foot week</b>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>fract neck left femur</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>Dec 28, 1954</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>her home Independence, Jackson, Mo</b>	21c. (CITY, TOWN, OR TOWNSHIP) <b>Indep</b> (COUNTY) <b>Jackson</b> (STATE) <b>Mo</b>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>Dec 28, 1954</b>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>fall in the home</b>
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22. I hereby certify that I attended the deceased from **Dec 28, 1954** to **9-14-1955** that I last saw the deceased alive on **9-13, 1955**, and that death occurred at **3:00 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Carl Allen M.D.</b> (Degree or title)	23b. ADDRESS <b>Independence Mo</b>	23c. DATE SIGNED <b>9/16/55</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Sept. 17, 1955</b>	24c. NAME OF CEMETERY OR CREMATORY <b>St. Marys</b>	24d. LOCATION (City, town, or county) <b>Indep, Mo.</b> (State)
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DATE REC'D BY LOCAL REG. <b>9-17-55</b>	REGISTRAR'S SIGNATURE <b>[Signature]</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Chas Mitchell</b>	ADDRESS <b>Indep. Mo.</b>
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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.....  
Licensed Embalmer No. 492

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.