

No. 300  
10.48

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

34103

State File No. ....

FILED NOV 9 1955

BIRTH NO. 58053-55 REG. DIST. NO. 217 PRIMARY REG. DIST. NO. 5787 Registrar's No. 76

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Mississippi</u>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Missouri</u> b. COUNTY <u>Miss.</u> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Charleston (rural)</u> |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Charleston (Rural)</u>                                    |  |
| c. LENGTH OF STAY (in this place) <u>life</u>  |  | d. STREET ADDRESS (If rural, give location) <u>Route 2</u>  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>Route 2</u>  |  |   |  |

|  |  |                              |   |  |   |
|--|--|------------------------------|---|--|---|
| 3. NAME OF DECEASED<br>(Type or Print) a. (First) <u>Dan</u> b. (Middle) _____ c. (Last) <u>Scott, Jr.</u> |  |                              | 4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 13, 1955</u> |  |   |
| 5. SEX <u>Male</u>   |  | 6. COLOR OR RACE <u>Col.</u> |   | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) _____ |   |
| 8. DATE OF BIRTH <u>Sept. 12, 1955</u>   |  |                              | 9. AGE (In years last birthday) _____                       |  | 10. IF UNDER 1 YEAR Months _____ Days _____                           |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____          |  |                              | 10b. KIND OF BUSINESS OR INDUSTRY _____                     |  | 11. BIRTHPLACE (State or foreign country) <u>Charleston, Missouri</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |                              |   |  |   |

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 13a. FATHER'S NAME <u>Dan Scott</u>  |  | 13b. MOTHER'S MAIDEN NAME <u>Celestine Rush</u> |  | 14. NAME OF HUSBAND OR WIFE _____   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____ |  | 16. SOCIAL SECURITY NO. _____                   |  | 17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Celestine Scott, R.2, Charleston, Mo.</u> ADDRESS _____ |  |

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Intracranial hemorrhage</u> |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> |
| ANTECEDENT CAUSES<br>Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  |  | DUE TO (b) <u>Probable birth injury</u>  |  |  |  |
|   |  | DUE TO (c) _____   |  |  |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.   |  | <u>7600</u>  |  |  |  |

|  |  |  |  |   |   |  |
|--|--|--|--|---|---|--|
| 19a. DATE OF OPERATION _____   |  | 19b. MAJOR FINDINGS OF OPERATION _____   |  |   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) <u>Sept 13 1955 10:30A</u> |  | 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 Sept 12, 1955 to Sept 13, 1955, that I last saw the deceased alive on Sept 13, 1955 and that death occurred at 10:30A m., from the causes and on the date stated above.

|   |  |                               |  |                                       |  |
|---|--|-------------------------------|--|---------------------------------------|--|
| 23a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>D.O.</u> |  | 23b. ADDRESS <u>Wyatt, Mo</u> |  | 23c. DATE SIGNED <u>Sept 14, 1955</u> |  |
|---|--|-------------------------------|--|---------------------------------------|--|

|   |  |                                 |  |  |  |  |  |
|---|--|---------------------------------|--|--|--|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> |  | 24b. DATE <u>Sept. 14, 1955</u> |  | 24c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u> |  | 24d. LOCATION (City, town, or county) (State) <u>Charleston, Mo.</u> |  |
|---|--|---------------------------------|--|--|--|--|--|

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| DATE REC'D BY LOCAL REG. <u>10/20/57</u> |  | REGISTRAR'S SIGNATURE <u>[Signature]</u> |  | 25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Charleston, Mo.</u> |  |
|--|--|--|--|--|--|

(Licensed Embalmer's Statement on Reverse Side)

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

NOV 4 REC'D

RECEIVED  
Miss. Co. Health Dept  
County File No. \_\_\_\_\_  
Date Filed NOV 7 1955

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 \_\_\_\_\_

*Body Not Embalmed*

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed *Frank J. Sparks*

Licensed Embalmer No. *3455*

P. O. Address *Osprey, Maryland*

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.

*OSPREY, MD*