

FILED OCT 17 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

33320

STATE FILE NUMBER

Registration District No. 389 Primary Registration District No. 5161 Registrar's No. 15

300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Callaway</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cedee TWP</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>New Bloomfield</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>West New Bloomfield - Life</u> Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <u>3 mi west N. B.</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Raymond</u> Last <u>Scott</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>11</u> Year <u>56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 12, 1914</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		9b. AGE (In years last birthday) <u>42</u>	9c. IF UNDER 1 YEAR Months <u>0</u> Days <u>29</u> Hours <u></u> Min. <u></u>
10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and state or country) <u>Guthrie Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Louis M. Scott</u>		14. MOTHER'S MAIDEN NAME <u>Stella Vaughn</u>	
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>no</u>	17. INFORMANT <u>Louis intended New Bloomfield</u> Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Gastro Enteritis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>7</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<u>5711</u>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a. m. _____ p. m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from <u>Sept 30-56 to Oct 11-56</u> and last saw <u>him</u> alive on <u>Sept 30-56</u> Death occurred at <u>7 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Ernest D. Puck M.D.</u>		22b. ADDRESS <u>New Bloomfield Mo</u>	22c. DATE SIGNED <u>Oct 12-56</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Oct 13-56</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Chapel Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>West Gilmer Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>Walter Claypool New Bloomfield</u>		25. DATE RECD. BY LOCAL REG. <u>10-12-56</u>	26. REGISTRAR'S SIGNATURE <u>Walter Claypool</u>

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em-  
by me, or by ....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Le Roy Claypool*.....

Licensed Embalmer No. *44*

P. O. Address *New Bloom*

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