

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

40791

STATE FILE NUMBER

FILED DEC 18 1956

Registration District No. 389 Primary Registration District No. 5761 Registrar's No. 19

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Callaway</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Holt Summit</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Holt Summit 040</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION			Length of stay in lb		d. STREET ADDRESS (If outside, give location) <u>8mi East Holt Summit</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Homer</u> Middle <u>Scott</u> Last <u>Scott</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>16</u> Year <u>56</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>NEURO</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG 9 - 1900</u>		9. AGE (In years last birthday) <u>56</u> IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (City and state or country) <u>New Bloomfield Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Milton Scott</u>				14. MOTHER'S MAIDEN NAME <u>Stella Vaughn</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>492-12-6374</u>		17. INFORMANT <u>Mrs Homer Scott</u> Address <u>Holt Summit Mo</u>				
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>VENTRICULAR FIBRILLATION</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>CORONARY HEART DISEASE</u> DUE TO (c) <u>RHUMATIC HEART DISEASE</u> 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>10 mo</u> <u>3 yrs</u> <u>20 yrs</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 _____ 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>March 25, 1956</u> to <u>Dec. 10, 1956</u> and last saw her/him alive on <u>Dec 10, 1956</u> Death occurred at <u>4 A M</u> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (In force or title) <u>William G. Dean M.D.</u>				22b. ADDRESS <u>500 Lafayette Jefferson City, Mo</u>				22c. DATE SIGNED <u>12/12/56</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Dec 13 - 56</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Dak Chapel Cemetery</u>		23d. LOCATION (City, town, or county) <u>Guthrie</u>		STATE <u>MO</u>	
24. FUNERAL DIRECTOR <u>Holt Claypool</u> ADDRESS <u>New Bloomfield</u>			25. DATE RECD. BY LOCAL REG. <u>12-12-56</u>		26. REGISTRAR'S SIGNATURE <u>John Claypool</u>				

(Licensed Embalmer's Statement on Reverse Side)

1th, 00 56  
lic fare  
vice  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
Coroner cannot certify to a death due to natural causes.  
Dector, coroner, etc. must be only diseases in Part I must be casually related.

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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.....  
Licensed Embalmer No. 44

P. O. Address New Bloom

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