

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

24816

STATE FILE NUMBER

FILED AUG 1 - 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3211

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Kansas</u> b. COUNTY <u>Wyndotte</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Menorah Medical Center <del>Burks</del></u>		Length of stay in lb	d. STREET (If outside, give location) ADDRESS <u>2317 Metropolitan</u>		Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Cecil</u> Middle <u>Edward</u> Last <u>Scott</u>			4. DATE OF DEATH Month <u>7</u> Day <u>8</u> Year <u>57</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>1-1-05 1909</u>	9. AGE (In years last birthday) <u>48</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Iron worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FACTORY</u>	11. BIRTHPLACE (City and state or country) <u>HANNIBAL Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>Clyde J. Scott Sr.</u>			14. MOTHER'S MAIDEN NAME <u>Bernice Leaks</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>515-09-9295</u>	17. INFORMANT <u>MRS. ANITA SCOTT, 2317 METROPOLITAN</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>Pulmonary congestion, bronchopneumonia + emaciation</u> DUE TO (b) <u>Recurrent carcinoma of the esophagus</u> 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>150X</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>6/4/57</u> to <u>7/8/57</u> and last saw <u>him</u> alive on <u>7/8/57</u> . Death occurred at <u>9:10 A. m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Arthur Adelman, M.D.</u>			22b. ADDRESS <u>701 E. 63rd St. K.C. Mo.</u>		22c. DATE SIGNED <u>7/10/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>July 11-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY Missouri</u>
24. FUNERAL DIRECTOR <u>Muehlebach Funeral Home (600 E. 1st)</u>		25. DATE RECD. BY LOCAL REG. <u>7-10-57</u>		26. REGISTRAR'S SIGNATURE <u>Yvonne Minshall</u>	

(Licensed Embalmer's Statement on Reverse Side)

1th, elfare ublic rvice

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Director, cordner, etc. must use only standard nomenclature in Part I. 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

Arthur Adelman, M.D.

MEDICAL CERTIFICATION

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 *Richard E. Nichols*.....

Licensed Embalmer No. *799*

P. O. Address *6600 I. Road  
P.C. Md.*

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.