

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-029994

State File No.

FILED SEP 2 1958

BIRTH NO. _____ REG. DIST. NO. ²⁹⁷4448 PRIMARY REG. DIST. NO. ⁴⁴⁴⁸6024 Registrar's No. ⁸⁷87

1. PLACE OF DEATH a. COUNTY <u>Ray Co</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Ray</u>	
b. CITY OR TOWN <u>Lawson</u>	c. LENGTH OF STAY (in this place) <u>74 years</u>	c. CITY OR TOWN <u>Lawson</u>	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		e. STREET ADDRESS <u>0890</u> (If rural, give location)	

3. NAME OF DECEASED (Type or Print) <u>MINNIE</u>	a. (First)	b. (Middle) <u>ALICE</u>	c. (Last) <u>SCOTT</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 19 1958</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>never married</u>	8. DATE OF BIRTH <u>Jan. 10, 1881</u>	9. AGE (In years last birthday) <u>77</u>	IF OVER 1 YEAR Months <u>7</u>	IF UNDER 1 YEAR Days <u>9</u>	IF UNDER 24 HRS. Hours <u></u>	Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Merchant</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <u>Garden Grove Iowa U.S.A.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Joseph P. Scott</u>	13b. MOTHER'S MAIDEN NAME <u>Alberta Young</u>	14. NAME OF HUSBAND OR WIFE
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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>4882436-8125</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Frank Scott</u>	ADDRESS <u>Lawson Mo</u>
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <u>Arteriosclerotic Hypertension</u>		
	DUE TO (b)		<u>5 year</u>
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? <u>2</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) <u>Lawson Ray Mo.</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from _____, 1950, to July 31, 1958, that I last saw the deceased alive on July 31, 1958, and that death occurred at 8 A. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Walter Buehler MD</u>	23b. ADDRESS <u>Lawson</u>	23c. DATE SIGNED <u>8/23/58</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Aug. 21, 58</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Lawson Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Lawson Mo</u>
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DATE REC'D BY LOCAL REG. <u>8-26-1958</u>	REGISTRAR'S SIGNATURE <u>Malcolm Jackson</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Lawson Funeral Home</u>	ADDRESS <u>Lawson Mo</u>
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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 *Lindee Jarman*

Licensee Embalmer No. *4589*
P. O. Address *Excelsior Spring Mo*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.