

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-005333  
STATE FILE NUMBER

FILED FEB 17 1959

Registration District No. 138 Primary Registration District No. Registrar's No. 9

300  
-57

1. PLACE OF DEATH a. COUNTY <i>Hickory</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Hickory</i>	
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) <i>Hermitage</i>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <i>Hermitage</i> <sup>0430</sup> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>1/2 mile E. Hermitage Mo.</i>		Length of stay in 1b <i>5 Mo.</i>	d. STREET ADDRESS (If outside, give location) <i>1/2 M. E. Hermitage</i> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <i>Minnie Cora Scott</i>			4. DATE OF DEATH Month Day Year <i>Feb 12-1959</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 27-1889</i>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	9. AGE (In years last birthday) <i>67</i> IF UNDER 1 YEAR: Months <i>5</i> Days <i>15</i> IF UNDER 24 HRS.: Hours <i></i> Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (City and state or country) <i>Nemo, Mo</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13a. FATHER'S NAME <i>William B. Jones</i>	
13b. MOTHER'S MAIDEN NAME <i>Sarah Jane Nelson</i>		14. NAME OF HUSBAND OR WIFE <i>Charles Scott</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Daniel Scott - Hermitage Mo</i>		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) <i>Cardiovascular renal disease</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Hypertension</i> DUE TO (c) <i></i>			INTERVAL BETWEEN ONSET AND DEATH <i>3 Wks.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>442X</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 <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 <i>Feb 1-59</i> to <i>Feb 12-59</i> and last saw her/him alive on <i>Feb 10-59</i> Death occurred at <i>12:05</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>C. O. Barclay</i>		(Degree or title) <i>2</i>	22b. ADDRESS <i>Hermitage Mo</i>
22c. DATE SIGNED <i>Feb 13</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <i>Feb-14-59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Hermitage Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Hermitage, Mo</i>
24. FUNERAL DIRECTOR <i>Hubert H. Thawway</i>		ADDRESS <i>Wheatland Mo</i>	25. DATE RECD. BY LOCAL REG. <i>Feb 14, 1959</i>
26. REGISTRAR'S SIGNATURE <i>Mary Johnson</i>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related

MAR 5 1967

### 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 *Chas. Gilbert Hathaway* .....

Licensed Embalmer No. *4267* .....

P. O. Address *Wheatland, W.V.*

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.