I DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS JAN 26 1960

60-000049
STATE FILE NUMBER

Registration District No. 4 Primary Registration District No. _____ Registrar's No. 129

1. PLACE OF DEATH a. COUNTY ATCHISON	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE IOWA b. COUNTY FREMONT
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN CLAY — Length of stay in 1b 2 DAYS	c. CITY OR TOWN HAMBURG, — Inside Limits Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 7 mi. S.W. ROCK PORT — Inside Limits Yes ☐ No ☒	d. STREET ADDRESS (If outside, give location) MAIN STREET — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First / Middle / Last: JAMES LaROY PORTER SCOTT		4. DATE OF DEATH Month / Day / Year: JANUARY 3, 1960	
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐	8. DATE OF BIRTH: 12-22-1880
9. AGE (last birthday): 79	IF UNDER 1 YEAR Months 0 Days 11	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER	10b. KIND OF BUSINESS OR INDUSTRY: FARM	11. BIRTHPLACE (City and state or country): ATCHISON CO., MO.	12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: GEORGE SCOTT	13b. MOTHER'S MAIDEN NAME: SARAH McCOY	14. NAME OF HUSBAND OR WIFE: ROSA SCOTT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) ----------	16. SOCIAL SECURITY NO.: 478-14-4916	17. INFORMANT: Mrs Lester Kerr — Address: ROCK PORT, MO.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary occlusion	10 min
DUE TO (b)	Arteriosclerotic Cardiovascular Disease	15 years
DUE TO (c)		

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Carcinoma Prostate

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 March 1953, to 3 Jan 60 and last saw her/him alive on 18 Dec 59

Death occurred at 1:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Harvey Henstorf MD	22b. ADDRESS: Shenandoah, Iowa	22c. DATE SIGNED: 7 Jan 60
23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL	23b. DATE: 1-3-1960	23c. NAME OF CEMETERY OR CREMATORY: HAMBURG CEMETERY.
23d. LOCATION (City, town, or county) (State): HAMBURG, IOWA.		
24. FUNERAL DIRECTOR: RASH FUNERAL HOME	ADDRESS: HAMBURG, IOWA	25. DATE RECD. BY LOCAL REG.: Jan 22, 1960
26. REGISTRAR'S SIGNATURE: Marvin H. Schaeler		

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed C. E. Burham

Signature of Student Embalmer

Licensed Embalmer No. 176

P. O. Address Rock Pon

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