

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

4039-61-029616- STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4039

FILED AUG 28 1961

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 1935		c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Elms Nursing Home			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3511 Highland		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First HAROLD Middle LOOK Last SCOTT				4. DATE OF DEATH Month Aug. Day 12, Year 1961									
5. SEX Male		6. COLOR OR RACE White		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 3-31-1883		9. AGE (last birthday) 78		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) agent				10b. KIND OF BUSINESS OR INDUSTRY FBI		11. BIRTHPLACE (City and state or country) Cincinnati, Ohio		12. CITIZEN OF WHAT COUNTRY USA					
13a. FATHER'S NAME Henry Scott				13b. MOTHER'S MAIDEN NAME Emma Look				14. NAME OF HUSBAND OR WIFE Agnes Mette Scott					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no						17. INFORMANT Address Mrs. Agnes M. Scott--3511 Highland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bacteremia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Chr. Ill. infection DUE TO (c) Cerebral Thrombosis										INTERVAL BETWEEN ONSET AND DEATH 3 days 3 wks 2 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
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 7:55 a.m. p.m. Month, Day, Year		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 July 7, 1961 to death and last saw him alive on Aug 14, 1961 . Death occurred at 7:55 A m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) John W. Hardy M.D.						22b. ADDRESS 1630 Prof Bldg R.C. 6 Mo			22c. DATE SIGNED Aug 14, '61				
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 8-15-61		23c. NAME OF CEMETERY OR CREMATORY Elmwood Crematory		23d. LOCATION (city, town, or county) (State) Kansas City, Missouri							
24. FUNERAL DIRECTOR Melody-McGilley-Eylar - 1800 E. Linwood				ADDRESS 8-14-61		25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE Ruth Long					

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF **John W. Hardy**

Dr. John Ha

HA 1-5037
arrange to
any time
except

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 Hal Joubert

Licensed Embalmer No. 3408

P. O. Address Indep., 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.