

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

1607-52-011337
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1607

FILED APR 5 1962

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>mo</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		c. CITY OR TOWN <u>Kansas City</u>	
Length of stay in lb <u>53 yrs</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>4878 Westwood Rd</u>		d. STREET ADDRESS (If outside, give location) <u>4828 Westwood Rd</u>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>NETTIE SPRINGER SCOTT</u>			4. DATE OF DEATH Month Day Year <u>3 17 - 1962</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5/24/1888</u>	9. AGE (last birthday) <u>77</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Lady</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery</u>		11. BIRTHPLACE (City and state or country) <u>Lexington Ky.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Wm E. Jones</u>		13b. MOTHER'S MAIDEN NAME <u>Belle Springer</u>		14. NAME OF HUSBAND OR WIFE <u>Geo. Dunlap Scott</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give War or dates of service) <u>yes</u>		16. SOCIAL SECURITY NO. <u>[redacted]</u>		17. INFORMANT <u>Mary Scott 4828 Westwood Rd.</u>			

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation due to</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 min</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Arterio sclerotic heart disease 100%</u>	
		DUE TO (c) <u>Generalized arteriosclerosis.</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Perniciosis Anemia</u>			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		
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 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 <u>1/55</u> to <u>3/17/62</u> and last saw her/him alive on <u>3-17-62</u> . Death occurred at <u>K. City mo</u> <u>7:20 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Degree or title) <u>Armedt Arma md</u>	22b. ADDRESS <u>4320 Womack Ave. mo</u>	22c. DATE SIGNED <u>3-19-62</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE <u>3/20/1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Edmunds Crematory</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City, mo</u>
24. FUNERAL DIRECTOR <u>C.H. Blackman & Son</u>	ADDRESS <u>K.C. mo</u>	25. DATE RECD. BY LOCAL REG. <u>3-20-62</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF DOCUMENT

VS 300 Rev. 4/59	DATE AMENDED	AMENDED	ITEM NO.	SHOULD READ	BY AFFIDAVIT OF	MEDICAL CERTIFICATION	APPROVED V. ATTEST
1							
23178							
3							
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8							
94200							
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11							
1290-0							
13							

#3206
Dr. Amos

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 Bert B. Bennett

Licensed Embalmer No. 4656

P. O. Address K.C., 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.