

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-049191

STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. 6074 Registrar's No. 516

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 2 1964

VS 300
Rev. 4/59

10940
20940

3 2
4 1
5 2
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260x
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12 90-0
13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Francois</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Leadwood</u>		c. CITY OR TOWN <u>Leadwood</u>	
Length of stay in lb <u>48 yrs.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u>		d. STREET ADDRESS (If outside, give location) <u>Leadwood</u>	
Inside Limits 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 First Middle Last <u>Iclean Scott</u>			4. DATE OF DEATH Month Day Year <u>Dec. 19, 1963</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>5-11-1891</u>
9. AGE (last birthday) <u>73</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (City, and state or country) <u>Washington Co. Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>George Beers</u>	
13b. MOTHER'S MAIDEN NAME <u>Eliza Jane Beers Skags</u>		14. NAME OF HUSBAND OR WIFE <u>William Houston Scott</u>	
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>None</u>	
17. INFORMANT <u>Mrs. Thelma Roux, Flat River, Mo.</u>		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) <u>DIABETIC GANGRENE BOTH FEET</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u>
DUE TO (b) <u>DIABETES MELLITIS</u>			<u>Not known</u>
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>HYPERTENSIVE CARDIOVASCULAR</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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, if any. If injury in PART I or PART II of item 18.) <u>—</u>	
20c. TIME OF INJURY Hour Month, Day, Year s.m. p.m.			
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>Aug 10 1963</u> to <u>Dec 19 1963</u> and last saw him alive on <u>Dec 10 1963</u> . Death occurred at <u>6:00 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Regd or title) <u>John W Hunt Jr M.D.</u>		22b. ADDRESS <u>Leadwood Mo.</u>	
22c. DATE SIGNED <u>12 20 1963</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12-21-1963</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Old Bonne Terre Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Bonne Terre, Mo.</u>	
24. FUNERAL DIRECTOR <u>Bert L. Boyer, Leadwood, Mo.</u>		25. DATE REC'D. BY LOCAL REG. <u>Dec. 20, 1963</u>	
26. REGISTRAR'S SIGNATURE <u>Cather Rudloff</u>			

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

Burd L. Ryan

Licensed Embalmer No. 5473

P. O. Address Leadwood 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.