MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

File No. 33656
Registered No. [illegible]

1. PLACE OF DEATH
County Jackson
Registration District No. 399
Township Kaw
Primary Registration District No. 1002
City Kansas City (No. Lake side Hospital St. Ward)

2. FULL NAME SCOTT Pernie Eve

(a) Residence. No. 2017 East 82 ndTerrace Ward. (Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	white	Married

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Lacy E Scott

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 15 1908

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
21	11	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) Home
(c) Name of employer Self

9. BIRTHPLACE (CITY OR TOWN) Fortuna
(STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER John C White
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Cooper County
(STATE OR COUNTRY) Missouri
12. MAIDEN NAME OF MOTHER Nellie Snyder
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Laclead County
(STATE OR COUNTRY) Missouri

14. INFORMANT Mrs Nellie R White
(Address) 2017 E 82nd Terrace

15. FILED 10/1, 1929 M. M. Crowe REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 1 1929

17. I HEREBY CERTIFY, That I attended deceased from Sept 30, 1929, to Oct 1, 1929,
that I last saw her alive on Oct 1, 1929, and that death occurred, on the date stated above, at 5 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute albuminaria
146 Uraemia
143B (duration) yrs. mos. 2 ds.

CONTRIBUTORY (SECONDARY) Pregnancy (duration) yrs. 8 mos. ds.

143

18. WHERE WAS DISEASE CONTRACTED K C Mo
IF NOT AT PLACE OF DEATH? 2017 E 82nd Terrace
Did an operation precede death? No Date of None
Was there an autopsy? No
What test confirmed diagnosis? Clinical & Lab
(Signed) George J Emery, M.D.
10/1, 1929 (Address) Lakeside Hospital

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Versailles Missouri
DATE OF BURIAL Oct 3 1929

20. UNDERTAKER McGilley McGilley Funeral Home Inc
ADDRESS Kansas City Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

THIS IS A PERMANENT RECORD

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

1. PLACE OF DEATH

County .... Registration District No. 399 File No. 4099

Township .... Primary Registration District No. 1002 Registered No. 4090

City Kans City (No. .... St. .... Ward)

2. FULL NAME Pernie Eve Scott

(a) Residence. No. .... St., ... Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS		
3. SEX F	4. COLOR OR RACE W	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 15 - 1907 (1908 struck)

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
21	11	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work........
(b) General nature of industry, business, or establishment in which employed (or employer)........
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)........
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)........
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)........
(STATE OR COUNTRY)

14. INFORMANT........
(Address)

15. FILED 10/1, 1929 M. M. Crowe REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 1 1929

17. I HEREBY CERTIFY, That I attended deceased from........, 19...., to........, 19...., that I last saw h.... alive on........, 19...., and that death occurred, on the date stated above, at........m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.... (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (SECONDARY)

.... (duration) ....yrs. ....mos. ....ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH........

DID AN OPERATION PRECEDE DEATH?........ DATE OF........

WAS THERE AN AUTOPSY?........

WHAT TEST CONFIRMED DIAGNOSIS?........

(Signed)........, M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
	19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

S-33656