

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

Do not use this space.

40161-a

PLACE OF DEATH

County Dade

Registration District No. 237

Township Greenfield

Primary Registration District No. 4144

City Greenfield

File No. _____

Registered No. 27

St. _____ Ward _____

2. FULL NAME

(a) Residence. No. _____ St. _____ 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

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

married

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

Evelyn Scroggs

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

Nov. 18-1843

7. AGE

YEARS 86

MONTHS 1

DAYS 6

IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

unknown

(STATE OR COUNTRY)

Arkansas

10. NAME OF FATHER

W. E. Scroggs

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

unknown

(STATE OR COUNTRY)

No. Carolina

12. MAIDEN NAME OF MOTHER

Jane Rachel Edwin

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

unknown

(STATE OR COUNTRY)

Arkansas

14. INFORMANT

Edwin Scroggs

(Address)

Greenfield Mo.

15. FILED

8-1-30

E. J. Ball

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 24 1929

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____,

that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at _____ 6:30 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchial Lung

Duration _____ yrs. 2 1/2 ds.

CONTRIBUTORY (SECONDARY) Old age _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, at Room of Hotel

DID AN OPERATION PRECEDE DEATH, NO DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? none

(Signed) F. J. Brown, M. D.

, 19 (Address) Greenfield Mo.

*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

Greenfield Cem

DATE OF BURIAL

12/26 1929

20. UNDERTAKER

Harrison and Co

ADDRESS

Greenfield 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.

2006-2018

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

PLACE OF DEATH

County Dade Registration District No. 237 File No.
 Township Greenfield Primary Registration District No. 4144 Registered No.
 City Greenfield St. Ward)

2. FULL NAME

John E. Scroggs
 (a) Residence, No. St. 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED M (write the word)

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
 (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)

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 9-9, 1930 B. G. Ball REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 24 1929

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

Broken limb
fall on sidewalk

18. WHERE WAS DISEASE CONTRACTED (duration) yrs. mos. ds.

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? DATE OF

WHAT TEST CONFIRMED DIAGNOSIS? 141

(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

20. UNDERTAKER ADDRESS

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

SUPPLEMENTARY

Handwritten text, possibly a name or signature, oriented vertically.

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