

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.

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

32254  
 Do not use this space.

OCT 23 1939

**1. PLACE OF DEATH**

(a) County Paducah Registration District No. 237  
 (b) Township CENTER Primary Registration District No. 4144 Registered No. \_\_\_\_\_  
 (c) City Greenfield, Mo. (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
 (e) Length of residence in city or town where death occurred 64 yrs. 1 mos. 10 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

**2. PRINT FULL NAME**

(a) Residence, No. Greenfield, Mo. St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 24, 1939

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

I HEREBY CERTIFY, That I attended deceased from Sept 1, 1939, to Sept 24, 1939  
 I last saw her alive on Sept 23, 1939. Death is said to have occurred on the date stated above, at 8:30 a.m.  
 The principal cause of death and related causes of importance were as follows:

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 14, 1875

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
18 7 5 Aug 14

Principal cause of death: Fractured hip!  
Cancer of breast  
 Date of onset \_\_\_\_\_  
 Other contributory causes of importance: \_\_\_\_\_

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_  
 9. Industry or business in which work was done, as saw mill, bank, etc. Housewife  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Greenfield, Mo., O

FATHER 13. NAME John F. Mitchell  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mississippi

MOTHER 15. MAIDEN NAME Mary Hajduk  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ark

17. INFORMANT (ADDRESS) E. J. Scroggs, Greenfield, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Greenfield, Mo. DATE Sept. 25, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Hermon Fann Home, Greenfield, Mo.

20. FILED 10-7-39 Geo. L. Weir Local Registrar.

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify \_\_\_\_\_ (Signed) H. A. Cowan, M. D.  
 \_\_\_\_\_ (Address) \_\_\_\_\_

RECEIVED

District Health Officer No. 6,

District File Number 1039-2127

Date filed OCT 20 1939

1944

WARRANT TO EXAMINE DECEASED PERSONS  
CORONERS DEPARTMENT  
CITY OF CHICAGO

HEAD OF BOARD OF HEALTH

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

Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed *Keith Collier*

Licensed Embalmer No. 3632

P. O. Address *Summit St*

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 this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

32254  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Dade Registration District No. 237  
 (b) Township Greenfield Primary Registration District No. 4144 Registered No. \_\_\_\_\_  
 (c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Kat Scroggs  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

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) Aug 14 - 1975

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>64</u>	<u>1</u>	<u>10</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_  
 9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

FATHER

13. NAME \_\_\_\_\_  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

MOTHER

15. MAIDEN NAME \_\_\_\_\_  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_  
 18. BURIAL, CREMATION, OR REMOVAL PLACE \_\_\_\_\_ DATE \_\_\_\_\_, 19\_\_\_\_  
 19. FUNERAL DIRECTOR (ADDRESS) \_\_\_\_\_

20. FILED 11-7-1935 Geo. L. Weir Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-24, 1939

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_  
 I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.  
 The principal cause of death and related causes of importance were as follows: \_\_\_\_\_  
 Date of onset \_\_\_\_\_

Other contributory causes of importance: \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify \_\_\_\_\_  
 (Signed) H. P. Coyle, M. D.  
 (Address) Greenfield Mo

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

SUPPLEMENTARY

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

322542  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Deda Registration District No. 237  
 (b) Township Greenfield Primary Registration District No. 4144 Registered No. \_\_\_\_\_  
 (c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Kat Seroggs  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 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) \_\_\_\_\_

7. AGE	YEARS	MONTHS	DAY	If LESS than 1 day, hrs. or min.
	<u>64</u>	<u>1</u>	<u>11</u>	

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_  
 9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

FATHER  
 13. NAME \_\_\_\_\_  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

MOTHER  
 15. MAIDEN NAME \_\_\_\_\_  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19

19. FUNERAL DIRECTOR (ADDRESS) \_\_\_\_\_

20. FILED \_\_\_\_\_ 19 \_\_\_\_\_

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 24, 1939

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_.

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:  
Fractured hip  
Cancer of liver  
 Date of onset \_\_\_\_\_

Other contributory causes of importance: 1960

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury 6-1, 1939  
 Where did injury occur? home  
 (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

Manner of injury fall on injury  
 Nature of injury big fracture

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify \_\_\_\_\_  
 (Signed) H. O. Cowan, M. D.  
 (Address) Greenfield mo

SUPPLEMENT

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

Important: Exact statement of OCCUPATION is very important.

Local Registrar.