

NOV 13 1939 **791**
Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH: **1003**

(a) County _____

(b) City or town **St Louis**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **2818 Delmar**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County _____

(c) City or town **St Louis** **21**
(If outside city or town limits, write "RURAL")

(d) Street No. **2818 Delmar**
(If rural, give location)

(e) ~~At residence of _____~~ _____ years.

3. (a) PRINT FULL NAME **JAMES SCROGGINS**

3. (b) If veteran, name war _____

3. (c) Social Security No. **211 721711**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **3**
year **1939** hour **2** minute **30** P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

4. Sex **male** 5. Color or race **negro**

6. (a) Single, widowed, married, divorced **m**

6. (b) Name of husband or wife **Jantha Scroggins**

6. (c) Age of husband or wife if alive **39** years

7. Birth date of deceased **Jan. 9 1903**
(Month) (Day) (Year)

Immediate cause of death _____

Due to **Pulmonary TB**

Due to **Tuberculosis**

Other conditions _____
(Include pregnancy within 3 months of death)

8. AGE: Years **36** Months **6** Days **23** If less than one day _____ hr. _____ min.

9. Birthplace **Lockesburg Ark.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Labor**

Major findings: _____
Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically

MOTHER FATHER

11. Industry or business _____

12. Name **Charlie Scroggin**

13. Birthplace **Lockesburg Ark**
(City, town, or county) (State or foreign country)

14. Maiden name **Mary Bright**

15. Birthplace **Lockesburg Ark**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Jantha Scroggin**

(b) Address **2818 Delmar**

17. (a) _____ (b) Date thereof **Oct 8, 1939**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Washington Pk**

18. (a) Signature of funeral director **W. J. ...**

(b) Address **2931 ...**

19. (a) **OCT 5 1939**
(Date received local registrar)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of place)

(e) Means of injury _____

23. Signature **Dr. ...** (M. D. or other)

Address **...** Date signed _____

MARGIN RESERVED FOR BINDING

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

Rev. 5-17-39
V. B. C. 2.
50M-5-17-39
1 X1931

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 Louis J. Atkins

Licensed Embalmer No. 2842

P. O. Address 3644 Finney

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.