

FILED JUN 6 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

19448

Registration District No. 934

Primary Registration District No. 6026

State File No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County St. Genevieve
(b) City or town Rural, ~~Union~~ Union ~~Union~~
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location) 20
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

8. (a) PRINT FULL NAME Died Unnamed (Scaggs)
8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May 25, 1940
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. 20 min. 0

9. Birthplace St. Gen. Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation _____
11. Industry or business _____
12. Name Fred Scaggs
13. Birthplace St. Francois Co. Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Lois Babb
15. Birthplace St. Gen. Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) Burial (b) Date thereof May 26, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Family cemetery

18. (a) Signature of funeral director None
(b) Address _____

19. (a) May 30-40 (b) Rev Joseph A. Garner
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Gen.
(c) City or town Rural, Union
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 25
year 1940 hour 11 minute 55 p. M.
21. I hereby certify that I attended the deceased from May 25
1940, 19____, to May 25, 1940

that I last saw him alive on May 25, 1940, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Premature birth of unknown cause. Duration _____

Due to _____
Due to _____

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

Major findings: Of operations _____
Of autopsy No

PHYSICIAN
Underline the cause to which death should be charged statistically.

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) Means of injury _____
23. Signature E. M. Stanley (City or town) (State) _____
Address Farmington, Mo. Date signed 5/27/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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.....

Licensed Embalmer No.....

P. O. Address.....

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.