

## FILED APR 2 1946 STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

17-39

Registration District No. 93Primary Registration District No. 5339Registrar's No. 24

## 1. PLACE OF DEATH:

(a) County Dade  
 (b) City or town Rural; Polk Township  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
6 miles E. of Greenfield  
 (If not in hospital or institution, write street number or location)  
None  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
None  
 In this community \_\_\_\_\_ (Specify whether)  
Lifetime  
 years, months or days)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39  
 (c) City or town Brookline 0  
 (If outside city or town limits, write "RURAL") 0  
 (d) Street No. Country  
 (If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country No.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 29  
 year 1946 hour 6 minute 45 P. M.

21. I hereby certify that I attended the deceased from viewed  
body at scene of accident - 3/29/46  
 that I last saw him alive on \_\_\_\_\_  
 and that death occurred on the date and hour stated above.

Immediate cause of death  
Crushed Chest.  
 Due to Truck accident

Duration

Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy none  
 ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED  
 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) Accident  
 (b) Date of occurrence March 29 - 1946  
 (c) Where did injury occur? Date Mo.  
 (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
7 Mi. East of Greenfield, Mo. on Hwy.  
 (Specify type of place) (e) Means of injury accident  
 While at work? Driving  
 23. Signature T. J. Drisdell, Cor. (M. D. or other)  
 Address Greenfield 810 Date signed \_\_\_\_\_

## 3. (a) PRINT FULL NAME GROVER SPENCER SCARBROUGH

3. (b) If veteran, name war No 3. (c) Social Security No. N

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Frances Scarbrough 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased January 15 1904  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
42 2 14 hr. \_\_\_\_\_ min.

9. Birthplace Willow Springs Missouri  
 (City, town, or county) (State or foreign country)

10. Usual occupation Farmer11. Industry or business Farm

MOTHER FATHER { 12. Name William H. Scarbrough  
 13. Birthplace No Record 9  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Mattie E. Scarbrough  
 15. Birthplace No Record 9  
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Frances Scarbrough(b) Address South Greenfield, Mo.

17. (a) Burial (b) Date thereof 3-31-46  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pennsboro Cemetery(a) Signature of funeral director Sam E. Senseney Jr.(b) Address Greenfield, Mo.

19. (a) 3-31-46 (b) Geo L. Weir  
 (Date received local registrar) (Registrar's signature)

74

(Licensed Embalmer's Statement on Reverse Side)

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

NOV 8 1954

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 Sam E. Seneaney Jr.  
Licensed Embalmer No. 4099  
P. O. Address. Greenfield, M

**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, fact should be so stated above.**

Registration District No. 9.3

Primary Registration District No. 5238

1. PLACE OF DEATH:

(a) County Oade  
(b) City or town Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(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)

3. (a) PRINT FULL NAME Louise S. Scarborough

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years 42 Months \_\_\_\_\_ Days \_\_\_\_\_ (If less than one day) hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) MO

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Registrar's signature)  
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to Not collision, by lost control of truck - on State maintained highway  
Other conditions 160 -  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy 1700-8  
28

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) Accident

(b) Date of occurrence March 29 - 46

(c) Where did injury occur? Oade MO

(d) Did injury occur in or about home, on farm, in industrial place, in public place? U.S. State maintained highway 160  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature T. J. Druehl (M. D. or other) \_\_\_\_\_

Address Springfield, MO Date signed 4/8/46

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

7840

SUPPLEMENTARY

8911