

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAY 20 1947

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 170

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

14
1
2

1. PLACE OF DEATH:

(a) County Callaway

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

(c) Name of hospital or institution: State Hospital 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 y 4 m 26 d
(Specify whether)

In this community same
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Laclede

(c) City or town Sebanon
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME EVERETTE SCAGGS

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 8 0

6. (b) Name of husband or wife _____

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

7. Birth date of deceased: 1 8 8 4
(Month) (Day) (Year)

8. AGE: Years 63 Months _____ Days _____ If less than one day
hr. _____ min. _____

MOTHER FATHER

9. Birthplace d/k 9
(City, town, or county) (State or foreign country)

10. Usual occupation d/k

11. Industry or business d/k

12. Name d/k

13. Birthplace d/k 9
(City, town, or county) (State or foreign country)

14. Maiden name d/k

15. Birthplace d/k 9
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital records

(b) Address Hulton Mo

17. (a) Burial (b) Date thereof: 4 17 47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Columbiaville Mo

18. (a) Signature of funeral director St. O. Roberts

(b) Address Columbiaville Mo

19. (a) 2-7-1947 (b) Joan Mansfield
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 4
year 1947 hour 3 minute 30 a. M.

21. I hereby certify that I attended the deceased from 5/3 1947 to 5/4/47 1947
that I last saw h. alive on 5/3/47 1947
and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic myocarditis

Due to _____

Due to _____

Other conditions: _____
(Include pregnancy within 8 months of death)

Major findings: AM
Of operations _____

Of autopsy _____

Duration _____

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)

(e) Means of injury _____

23. Signature J Caldwell (M. D. or other) July 9
Address Hulton Mo Date signed 5/4/47

Date Filed 5-17-42
District File Number

District Health Officer No. 9

RECEIVED

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, fact should be so stated above.