

FILED APR 18 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 391

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

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Springfield</u>	c. LENGTH OF STAY (in this place) <u>2 Years</u>	c. CITY (If outside corporate limits, write RURAL and give township) <u>Springfield,</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1011 West State</u>		d. STREET ADDRESS (If rural, give location) <u>1011 West State</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>James</u>	b. (Middle) <u>F</u>	c. (Last) <u>Scroggins</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>April 7 1949</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 19, 1877</u>	9. AGE (In years last birthday) <u>72</u>	IF UNDER 1 YEAR Months	IF UNDER 12 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>General Farming</u>	11. BIRTHPLACE (State or foreign country) <u>Polk Co., Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>John B. Scroggins</u>	13b. MOTHER'S MAIDEN NAME <u>Mary R Degraffenreid</u>	14. NAME OF HUSBAND OR WIFE <u>Gertrude Scroggins</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Gertrude Scroggins, Springfield, Mo.</u>	ADDRESS <u>Springfield, Mo.</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Neurosis</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension</u> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Blindness 13 1/2 y</u>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>none</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>none</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>none</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>none</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>None</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>none</u>
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22. I hereby certify that I attended the deceased from 4-10, 1949, to 4-7, 1949, that I last saw the deceased alive on 4-7, 1949, and that death occurred at 8:40 A.M., from the causes and on the date stated above.

23a. SIGNATURE <u>D. F. Freeman</u>	(Degree or title)	23b. ADDRESS <u>Springfield, Mo</u>	23c. DATE SIGNED <u>4/8/49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>April 10, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Slagle Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Near Slagle, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>4/11/49</u>	REGISTRAR'S SIGNATURE <u>W. S. Handley MD</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Alma Lohmeyer</u>	ADDRESS <u>Funeral Home, Springfield, Mo.</u>
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APR 13 1964

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

Bernard F. Wright

Signed _____

Student Embalmer

Licensed Embalmer No. *4293*

P. O. Address _____

Springfield

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.