

FILED DEC 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39276

State File No. _____

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **10460**

1. PLACE OF DEATH a. COUNTY 3		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY OR TOWN St. Louis Missouri		c. CITY OR TOWN St. Louis	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 1405 Hampton	
d. FULL NAME OF HOSPITAL OR INSTITUTION Enroute City Hospital		4. DATE OF DEATH (Month) (Day) (Year) 12 2 49	
3. NAME OF DECEASED a. (First) Leonard b. (Middle) G c. (Last) Scoggins		5. SEX Male	
6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	
8. DATE OF BIRTH 7-31-1928		9. AGE (In years last birthday) 21	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) St. Louis Mo		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME George Scoggins		13b. MOTHER'S MAIDEN NAME Lois Connley	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W. 2	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME George Scoggins 1830A Menard	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Fr of skull; Subdural hemorrhage ANTECEDENT CAUSES suffered when motorcycle operated by deceased struck parked truck in front of apartment 5081 Manchester, approx 10:15 pm Dec 2 1949 II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Accident	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT (Specify) Accident	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Louis Mo 110	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Dec 2 49 10:15 p.m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 27		22. I hereby certify that I attended the deceased from 2 , 19 49 , to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 10:15 p.m. , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) Patrick E. Taylor Coronar		23b. ADDRESS 1300 Clark	
23c. DATE SIGNED 12 5 49		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE 12-6-49		24c. NAME OF CEMETERY OR CREMATORY National Cem.	
24d. LOCATION (City, town, or county) (State) St. Louis Mo.		DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE DEC 5 1949 J. B. Laster	
25. FUNERAL DIRECTOR'S SIGNATURE Myrdell Funeral Home		ADDRESS 1926 Allen	

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

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 me

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed Dale A. Staumann

Licensed Embalmer No. 4533

P. O. Address 1926 Allen

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.