

FILED OCT 20 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **88162**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 111 PRIMARY REG. DIST. NO. 4183 Registrar's No. 44

1. PLACE OF DEATH a. COUNTY <u>Franklin</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Pacific</u>		c. LENGTH OF STAY (In this place) <u>✓</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION _____		c. CITY (If outside corporate limits, write RURAL and give township) <u>R.F.D. #1 Pacific 4000</u>	
		d. STREET ADDRESS (If rural, give location) <u>1</u>	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) <u>Leroy</u>	b. (Middle) <u> Dale</u>	c. (Last) <u> Scoggins</u>	(Month) <u>Oct.</u>	(Day) <u>7</u>	(Year) <u>1950</u>

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>Febr. 19, 1903</u>	9. AGE (In years last birthday) <u>47</u>	IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u>	IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u>
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10a. USUAL OCCUPATION (Give kind of work or during most of working life, even if retired) <u>Laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Gen'l Labor</u>	11. BIRTHPLACE (State or foreign country) <u>Venice, Ill.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Rolland Scoggins</u>	13b. MOTHER'S MAIDEN NAME <u>Eva Reed</u>	14. NAME OF HUSBAND OR WIFE <u>Elizabeth Scoggins</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year and date of service) _____	16. SOCIAL SECURITY NO. <u>489-01-6823</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Elizabeth Scoggins</u> ADDRESS _____
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH  <u>6802</u>  <u>35</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Fractured skull</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>struck by west bound</u> DUE TO (c) <u>FRISCO TRAIN #31</u>		
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 _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Railroad track</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Pacific, Franklin, Mo.</u>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Oct. 7, 1950</u> m. _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23a. SIGNATURE <u>Mrs. P. Shaffer</u> (Name or title)	23b. ADDRESS <u>Sullivan Mo</u>	23c. DATE SIGNED <u>10/9/50</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Oct 8, 1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Gilead Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>Green, Co. Ill.</u>
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DATE REC'D BY LOCAL REG. <u>Oct 14 1950</u>	REGISTRAR'S SIGNATURE <u>Mary B. Gross</u>	94	25. FUNERAL DIRECTOR'S SIGNATURE <u>Geo. L. Shipes</u>	ADDRESS <u>Pacific Mo</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

File No. \_\_\_\_\_  
DISTRICT HEALTH OFFICE No. 4

OCT 19 1950

RECEIVED

JUL 9 1952

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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed *J. M. L. Heber*

Signed.....  
Student Embalmer

Licensed Embalmer No. 3008

P. O. Address Pacific 220

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.