

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**-61-036618**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DP. MAIDUX  
AMENDED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1005

STATE FILE NUMBER

**FILED OCT 30 1961**

DATE AMENDED

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>GREENE</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>SPRINGFIELD</b>		c. CITY OR TOWN <b>SPRINGFIELD</b>	
Length of stay in 1b <b>35 YRS.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. JOHN'S HOSP.</b>		d. STREET ADDRESS (If outside, give location) <b>1643 S. KIMBROUGH</b>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <b>L. GUY SCROGGINS</b>			4. DATE OF DEATH Month Day Year <b>OCT. 21 1961</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7/28/05</b>	9. AGE (last birthday) <b>56</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED OWNER,</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>COLONIAL BARBER SHOP</b>		11. BIRTHPLACE (City and state or country) <b>POLK COUNTY, MO.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>

13a. FATHER'S NAME <b>CHARLES SCROGGINS</b>		13b. MOTHER'S MAIDEN NAME <b>MATTIE HELEN SPENCER</b>		14. NAME OF HUSBAND OR WIFE <b>JUNE K. SCROGGINS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>JUNE K. SCROGGINS, SPRINGFIELD, MO.</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brain Abscess</b>		INTERVAL BETWEEN ONSET AND DEATH <b>?</b>
DUE TO (b) <b>Empyema Rt Chest.</b>		<b>Sept 1960</b>
DUE TO (c) <b>Rupture esophagus</b>		<b>Sept 1960</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>SPRINGFIELD, MO.</b>	COUNTY <b>GREENE</b>	STATE <b>MO.</b>
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21. I attended the deceased from 7-4-59 to 10-21-61 and last saw him alive on 10-21-61  
Death occurred at 1:40 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>J.P. Maddux M.D.</b>	22b. ADDRESS <b>Springfield, Mo</b>	22c. DATE SIGNED <b>10/23/61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>10/24/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MAPLE PARK</b>	23d. LOCATION (City, town, or county) <b>SPRINGFIELD, MO.</b>	(State)
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24. FUNERAL DIRECTOR ADDRESS <b>H.H. LOHMEYER FUNERAL HOME SPRINGFIELD, MO.</b>	25. DATE RECD. BY LOCAL REG. <b>10-24-61</b>	26. REGISTRAR'S SIGNATURE <b>Ellis E. Melton</b>
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

OCT 30 1961

MAY 29 1962

OCT 31 1961

**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.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed W. H. McCann

Licensed Embalmer No. 2727

P. O. Address Spokane

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.