

1939 MAY 12

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

15910

Do not use this space.

1. PLACE OF DEATH

(a) County Reynolds Registration District No. 1158  
 (b) Township Webb Primary Registration District No. 5983 Registered No. \_\_\_\_\_  
 (c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Louis Green Scaggs  
 (a) Residence, No. Reynolds Co. St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 27-1855

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
83 5 22

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_  
 9. Industry or business in which work was done, as saw mill, bank, etc. farmer  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Reynolds Co. Mo.

FATHER 13. NAME Silas Scaggs

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn

MOTHER 15. MAIDEN NAME Polly Hampton

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn

17. INFORMANT (ADDRESS) Pete Scaggs

18. BURIAL, CREMATION, OR REMOVAL PLACE Hampton Cemetery DATE 4-26-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Coy. Leichel

20. FILED \_\_\_\_\_ 19 \_\_\_\_\_ Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-25-1939

22. I HEREBY CERTIFY, That I attended deceased from 4/11 1939 to 4/25 1939

I last saw him alive on 4/24 1939. Death is said to have occurred on the date stated above, at 8:25 A.M.

The principal cause of death and related causes of importance were as follows:

Metastatic Carcinoma of left lung

Other contributory causes of importance: Carcinoma of Rectum and Prostate

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19 \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) E. B. Hall, M. D.

(Address) Elmington Mo

673

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very importa.

46

**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 4-25-39

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed Philip A. Leuchel

Licensed Embalmer No. 2936

P. O. Address Von Bremen

**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, above space should be left blank.**

STATEMENT BY LICENSED EMBALMER

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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1. PLACE OF DEATH  
 (a) County Reynolds Registration District No. 1108  
 (b) Township Webb Primary Registration District No. 3983 Registered No. 5  
 (c) City ..... (d) Street No. .... St. ....  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Louis Green Seaggy  
 (a) Residence, No. Reynolds Co. St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 9-27-1853

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hr. or ..... min.  
83 5- 22

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Reynolds Co. Mo.

FATHER  
 13. NAME Silas Seaggy  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn.

MOTHER  
 15. MAIDEN NAME Polly Hampton  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Webb

17. INFORMANT (ADDRESS) Peter Seaggy no Ellington Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Hampton Cem DATE 4-26-39

19. FUNERAL DIRECTOR (ADDRESS) Croy Leichel Ellington Mo.

20. FILED 6-8-39 V. O. Wiley M.D. Local Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-25-1939

22. I HEREBY CERTIFY, That I attended deceased from 2/11/36, to 4-25-1939  
 I last saw him alive on 4/24, 1939. Death is said to have occurred on the date stated above, at 8:25 a.m.  
 The principal cause of death and related causes of importance were as follows:  
metastatic carcinoma of left lung  
 Date of onset

Other contributory causes of importance:  
carcinoma rectum and prostate

Name of operation ..... Date of .....  
 What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? ..... Date of injury ..... 19.....  
 Where did injury occur? ..... (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....  
 Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased?  
 If so, specify ..... (Signed) L. B. Ralls M. D.  
 (Address) Ellington Mo.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.  
 Every year or more than one year or carefully supplied. AGE should be stated EXACTLY. PHYSICIANS SHOULD STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Louis Green Seagr

(a) Residence, No. \_\_\_\_\_ St. 9 (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-25-1939

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

The principal cause of death and related causes of importance were as follows:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
83 0 22

metastatic Carcinoma Date of onset  
of left lung 51

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_  
9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_

11. Total time (years) spent in this occupation \_\_\_\_\_

Other contributory causes of importance:  
Carcinoma of Rectum and Prostate (Prostate initial site)

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

FATHER 13. NAME

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

23. If death was due to external causes (violence), fill in also the following:

MOTHER 15. MAIDEN NAME

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

17. INFORMANT (ADDRESS)

Specify whether injury occurred in industry, in home, or in public place.

18. BURIAL, CREMATION, OR REMOVAL

Manner of injury \_\_\_\_\_

PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19\_\_\_\_

Nature of injury \_\_\_\_\_

19. FUNERAL DIRECTOR (ADDRESS)

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

20. FILED \_\_\_\_\_, 19\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) L. F. Ralls, M. D.

(Address) Ellington Mo

Local Registrar.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

AGE should be stated EXACTLY. PHYSICIAN should state