

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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 important.

social security no - none.

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

21356
Do not use this space.

1. PLACE OF DEATH

(a) County Callaway - 3 Registration District No. 104
(b) Township Fulton Primary Registration District No. 3008 Registered No. 166
(c) City Fulton (d) Street No. State Hospital #1 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 49 yrs. 1 mos. 2 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 620 Oscar W. Scruggs
Montgomery County, Mo (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) S.

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) ? 1870

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
70 70 ? 2

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)

Labour
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Charles County Mo

FATHER 13. NAME O Link

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 9 Link

MOTHER 15. MAIDEN NAME 9 Link

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 9 Link

17. INFORMANT (ADDRESS) State Hosp #1 Fulton Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Hospital Grounds DATE June 27 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) R. N. Creve 362 Market St Fulton Mo

20. FILED June 27 1940 R. N. Creve Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-24 1940

22. HEREBY CERTIFY, That I attended deceased from

June 30 1938, to June 24 1940
I last saw him alive on June 23rd 1940 Death is said to have occurred on the date stated above, at 3:20 A.M.

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

Left Hemiplegia with Bronchopneumonia (bilateral)
Date of onset 6/19/40
6/21/40

Other contributory causes of importance:

Senility
Arteriosclerosis

Name of operation _____ Date of _____

What test confirmed diagnosis? Phys. Ex. Was there an autopsy? Yes.

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

Accident, suicide, or homicide? no 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? no

If so, specify _____

(Signed) R. N. Creve, M. D.

(Address) State Hosp #1 Fulton Mo

1072

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **21356**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **104**

Primary Registration District No. **3008**

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County **Callaway**
(b) City or town **Fullon**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME **Oscar W. Scruggs**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **s**

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____
If less than one day _____ h. _____ min.

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **6** day **24**
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Left Ventricular Failure with Bronchopneumonia**
Due to **Cerebral Hemorrhage 6/24/48**

Due to _____

Other conditions **Senility**
(Include pregnancy within 3 months of death)

Major findings: **arteriosclerosis**
Of operations _____

Of autopsy **820'**

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature **Geo. F. Wood** (M. D. or other) _____
Address **State Hosp #9 Fullon Mo** Date signed _____

SUPPLEMENTAL

