No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED OCT 6 1947

Registration District No. 42

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1000

State File No. 30466

Registrar's No. 1155

1. PLACE OF DEATH:
(a) County: Buchanan
(b) City or town: St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Missouri Methodist Hospital
(If not in hospital or institution, write street address or location)
(d) Length of stay: In hospital or institution: 14hrs. 30 min.
In this community: Lifetime (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Buchanan
(c) City or town: 622 No. 12th St.
(If outside city or town limits, write "RURAL")
(d) Street No.: St. Joseph, Missouri
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: Luana K. Scroggins
3. (b) If veteran, name war: None
3. (c) Social Security No.: None
4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, divorced: Single
6. (b) Name of husband or wife: no
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: September 27, 1947 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
0	0	0	14 hr. 30 min.

9. Birthplace: St. Joseph, Missouri (City, town, or county) (State or foreign country)
10. Usual occupation: Infant
11. Industry or business: None
FATHER
12. Name: Dwight Scroggins
13. Birthplace: Forbes, Missouri (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name: Maxine Moore
15. Birthplace: Fortescue, Missouri (City, town, or county) (State or foreign country)
16. (a) Informant: Dwight Scroggins (father)
(b) Address: 622 No. 12th St., City
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9/29/47 (Month) (Day) (Year)
(c) Place: burial or cremation: Osborne, Missouri
18. (a) Signature of funeral director: John C. Ruff
(b) Address: 6054 Pryor Ave., City
19. (a) Sept 29 1947 (Date received local registrar) (b) C. C. Fontaine (Registrar's signature) 393

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 27, year 1947 hour 9 minute 40: P. M.
21. I hereby certify that I attended the deceased from 9-27-47, 19..., to 9-27-47, 19...; that I last saw her alive on 9-27-47, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Premature Birth 6½ mo	15 hr
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations: 59
Of autopsy:

PHYSICIAN
Underline the cause of 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? (Specify type of place)
While at work? (e) Means of injury:
23. Signature: H. A. Kearby (M. D. or other) M.D.
Address: St Joseph Mo Date signed 9-28-47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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 Roland D. Clark Registered Apprentice No. 503, working under my personal supervision.

Signed John E. Rupp

Licensed Embalmer No. 3986

P. O. Address St. Joseph, Mo.

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.