

FILED AUG 22 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25868

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 720

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Wright	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. LENGTH OF STAY (If in place) 2 days	c. CITY OR TOWN Mt. Grove
d. FULL NAME OF HOSPITAL OR INSTITUTION Springfield Baptist Hospital		e. STREET ADDRESS (If rural, give location) Route 2	

3. NAME OF DECEASED (Type or Print) a. (First) Fannie b. (Middle) Love c. (Last) Scroggins	4. DATE OF DEATH (Month) (Day) (Year) August 16, 1955
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH February 23, 1891	9. AGE (In years last birthday) 64	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (City and State or Foreign Country) Polk County, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME William Dunn	13b. MOTHER'S MAIDEN NAME Zora Holman	14. NAME OF HUSBAND OR WIFE Glenn E. Scroggins
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME Glenn E. Scroggins ADDRESS Mt. Grove,
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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, asthma, etc. It means the disease, injury, or complication which caused death.	19. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Strangulated Ventral Hernia		48 Hrs.
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Atelectasis of lungs		

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION Strangulated V. Hernia + 2 other large ventral hernias	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) + (COUNTY) (STATE) Deerfield, Greene, Missouri
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from **8-14, 1955**, to **8-16, 1955**, that I last saw the deceased alive on **8-16, 1955**, and that death occurred at **6:55 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Gene W. Farthing, M.D.	23b. ADDRESS 808 2nd St. S. Springfield, Mo.	23c. DATE SIGNED 8-16-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE August 17, 1955	24c. NAME OF CEMETERY OR CREMATORY _____	24d. LOCATION (City, town, or county) (State) Bolivar, Missouri
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DATE REC'D BY LOCAL REG. 8-17-55	REGISTRAR'S SIGNATURE Gene W. Farthing	25. GENERAL DIRECTOR'S SIGNATURE Gene W. Farthing ADDRESS Bolivar, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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..... *Lewis Gleichauf*

Licensed Embalmer No. *380*

P. O. Address *Springfield*

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.