

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

Do not use this space.

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1. PLACE OF DEATH

County W. Bolton Registration District No. 253
 Township Jackson Primary Registration District No. 535B
 City Bellevue (No.) St. Ward)

File No. 2
 Registered No.

2. FULL NAME M. M. Skidner

(a) Residence. No. St. Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Married
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 19-1868
 7. AGE YEARS 59 MONTHS 2 DAYS 22 If LESS than 1 day, hrs. or min.
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Farmer
 (b) General nature of industry, business, or establishment in which employed (or employer) ✓
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN; STATE OR COUNTRY) Mo

10. NAME OF FATHER Chas. Skidner

11. BIRTHPLACE OF FATHER (CITY OR TOWN; STATE OR COUNTRY) Mo

12. MAIDEN NAME OF MOTHER Rebecca Smith

13. BIRTHPLACE OF MOTHER (CITY OR TOWN; STATE OR COUNTRY) Mo

14. INFORMANT J. Baker
 (Address) Loce Springs Mo

15. FILED Jan 10, 1927 A. S. Minick REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 10 1927
 17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1927 to Jan 10 1927
 that I last saw him alive on Jan 9 1927 and that death occurred, on the date stated above, at 10 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Epileptic fits

CONTRIBUTORY (SECONDARY) 85
 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH?

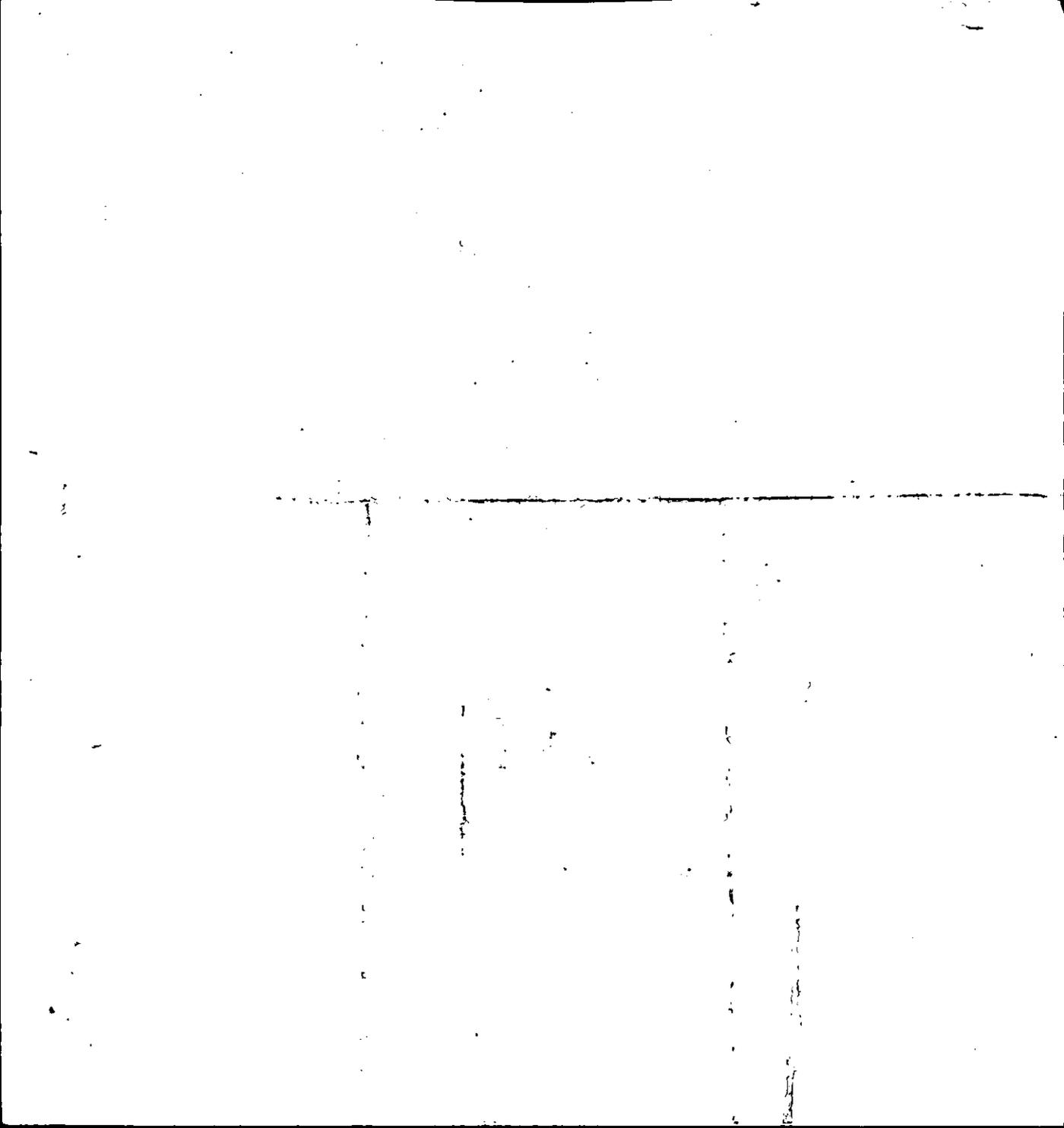
8 DID AN OPERATION PRECEDE DEATH?

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) A. S. Minick, M. D.

Jan 10, 1927 (Address) Loce Springs Mo
 *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. 2 1/2 mi N-W Jackson Mo

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Clearcreek Cemetery DATE OF BURIAL Jan 13 1927

20. UNDERTAKER F. B. Norman ADDRESS Bellevue Mo



**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Daviess Registration District No. 253 File No.
Township Jackson Primary Registration District No. 5351 Registered No. 2
City St. Ward)

2. FULL NAME

M. M. Gardner
(a) Residence. No. St. Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (prior the word) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 19, 1868

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1
				day, hrs. or min.
<u>59</u>	<u>2</u>	<u>21</u>		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

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

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED Dec 10 1928 G. M. Minter REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 10, 1929

17. I HEREBY CERTIFY That I attended deceased from to
that I had saw h..... alive on 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed), M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

19

20. UNDERTAKER ADDRESS

RARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNPIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

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