

PR 30/1929

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 Pemiscot Registration District No. 655  
Township Holland Primary Registration District No. 5822  
City Holland (No. ....) St. .... Ward)

2. FULL NAME

Clarence Skweis  
(a) Residence. No. Holland St. .... Ward. ....  
(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF <u>X</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>11-21-1905</u>		
7. AGE <u>23</u>	YEARS <u>0</u>	MONTHS <u>16</u>
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>X</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>X</u> (c) Name of employer <u>X</u>		

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

PARENTS	10. NAME OF FATHER <u>B. W. Skweis</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Madisonville</u> (STATE OR COUNTRY) <u>Ky</u>
	12. MAIDEN NAME OF MOTHER <u>Smith</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>Sarahgorty</u> (STATE OR COUNTRY) <u>Tenn.</u>

14. INFORMANT (Address) .....

15. FILED....., 19... Max S. Kelly  
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-7-1928

17. I HEREBY CERTIFY, That I attended deceased from 11-30-1928, to 12-6-1928, that I last saw him... alive on 12-6-1928, and the death occurred, on the date stated above, at 1:00 A.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Paraplegia  
Complicated:- Alcoholism  
(duration)..... yrs. .... mos. 10 ds.

CONTRIBUTORY (SECONDARY) 175/10  
(duration)..... yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH... X  
DID AN OPERATION PRECEDE DEATH... W DATE OF... X

WAS THERE AN AUTOPSY? no  
WHAT TEST CONFIRMED DIAGNOSIS...  
(Signed) L. E. Cooper, M. D.  
12-8-1928 (Address) Osaker 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.

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

20. UNDERTAKER ADDRESS

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.

old state

State of Illinois  
Exact state

form

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Jennett  
Township Holland  
City (No. \_\_\_\_\_) \_\_\_\_\_

Registration District No. 656  
Primary Registration District No. 5872

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Clarence Stivers  
(a) Residence. No. Holland St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred 12 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 S (prior the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 11-21-1905

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
<u>23</u>	<u>1</u>	<u>16</u>		

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work \_\_\_\_\_  
(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

**PARENTS**  
10. NAME OF FATHER B.W. Stivers  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Madisonville Ky.  
12. MAIDEN NAME OF MOTHER Smith  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Sarahsville Tenn

14. INFORMANT (Address) \_\_\_\_\_

15. FILED 5-18-1929 James O Jones REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12/7 1928

17. I HEREBY CERTIFY That I attended deceased from 11-30 to 12-6 1928 that I last saw him alive on 12-6, 1928, and that death occurred, on the date stated above, at 11 a.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:  
Paraplegia  
Complicated - Alcoholism  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 10 ds.

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

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

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_

(Signed) D. E. Cooper M. D.  
12-8, 1928 (Address) Paster 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL St. Paul Knoll DATE OF BURIAL Jan 12 1929

20. UNDERTAKER St. Paul Knoll ADDRESS St. Paul Knoll

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

SUPPLEMENTARY

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