

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

Do not use this space.

10796

1. PLACE OF DEATH

County Jackson
Township Mean
City Kansas City (No. Kansas City Genl Hosp)

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. 1315
St: _____ Ward)

2. FULL NAME Skinner, Shirley

(a) Residence. No. 1703 Astor St. 11 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 F. 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Child

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 9 1929

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min. 5

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(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 Ernest Skinner

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

12. MAIDEN NAME OF MOTHER Lula Meek

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

14. INFORMANT Rebecca Clark (Address) K.C. Genl Hosp.

15. FILED 3/15 1929 M. M. Croome REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-14 1929

17. I HEREBY CERTIFY, That I attended deceased from 3-9 1929 to 3-14 1929, 19.29 that I last saw him alive on 3-14 1929, 19.29 and that death occurred, on the date stated above, at 8:15 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchopneumonia
1929
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) Cerebral hemorrhage?
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED 74th St
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clin Findings
(Signed) P. E. Williams M. D.

3-15 1929 (Address) Subt K.C. Genl Hosp

*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 Woodlawn Cem DATE OF BURIAL March 17 29

20. URBERTAKER Rosa Anderson ADDRESS 1572 Julia

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.

WHILE FURNISHING WITH CONTINUING INK—THIS IS A PERMANENT RECORD

