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

Do not use this space.

34755

1. PLACE OF DEATH
County Putnam
Township York
City ..... (No. ..... St. ..... Ward)

Registration District No. 724
Primary Registration District No. 5955

File No. .....
Registered No. 8

2. FULL NAME Susie Mello Skipper

(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: Female

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 Robert R Skipper

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 5 1875

7. AGE: Years 54 | Months 5 | Days 12 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House 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) Putnam Co Mo

PARENTS

10. NAME OF FATHER Henry S. Mello

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

12. MAIDEN NAME OF MOTHER Nancy J Owings

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

14. INFORMANT Robert R Skipper
(Address) Powersville Mo.

15. FILED 10-18 1929 F A Fogel REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 17 1929

17. I HEREBY CERTIFY, That I attended deceased from Sept. 30, 1929, to Oct 17, 1929 that I last saw h..... alive on Oct 16, 1929, and that death occurred, on the date stated above, at 6 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lemphagia gel gangrene from Cerebral hemorrhage
132A
82A
(duration) ..... yrs. ..... mos. 17 ds.

CONTRIBUTORY (SECONDARY) Nephritis
(duration) Several months yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED Home
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS .....
(Signed) F A Fogel, M. D.
10/18 1929 (Address) Powersville 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 Wyreka Cemetery
DATE OF BURIAL Oct 18 1929

20. UNDERTAKER Constock Merc Co
ADDRESS Unionville

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.