

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

Do not use this space.

36473

1. PLACE OF DEATH

County Butter
Township Poplar Bluff
City Poplar Bluff (No. _____)

Registration District No. 89
Primary Registration District No. 3007

File No. _____
Registered No. 202
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode) Paris M. Skidmore (If nonresident, give city or town and State) Paris
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 (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 22, 1903

7. AGE 26 YEARS MONTHS 7 DAYS 17 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) Dunklin Co. Mo.
(STATE OR COUNTRY) _____

10. NAME OF FATHER Gay Skidmore
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Dunklin Co. Mo.
(STATE OR COUNTRY) _____
12. MAIDEN NAME OF MOTHER Rodie Lee
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY) _____

14. INFORMANT Milo Skidmore
(Address) Piggot, Ark. RR 4

15. F. I. D. No. 1929 Dr. J. C. M.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-17-1929

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at 4:40 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Fracture of skull above, and behind right ear, knocked from wagon caused by auto colliding with rear end, on highway 63 about 12 miles south east Poplar Bluff (accidental)
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) Grove Green

11/18, 1929 (Address) Poplar Bluff 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 Gravel Hill DATE OF BURIAL 11-19 1929

20. UNDERTAKER Franklund Co. Poplar Bluff Mo.

26-8-25



**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 Butler Registration District No. 89 File No. _____
 Township _____ Primary Registration District No. 3009 Registered No. 202
 City Douglas Bluff (No. _____) St. _____ Ward _____

2. FULL NAME

(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 (*write the word*) m

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 22-1903

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
26 8 25

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) _____ (duration) _____ yrs. _____ mos. _____ ds.
 (c) Name of employer _____

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

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) Not known (STATE OR COUNTRY) _____

14. INFORMANT _____ (Address) _____

15. FILED 1/6 1930 Dr. J. J. Clark REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-17-1929

17. I HEREBY CERTIFY That I attended deceased from _____, 19____ to _____, 19____ that I last 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.

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

20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

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

5-36473

UNITED STATES GOVERNMENT

OFFICE OF THE SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301

FORM NO. 101 (REV. 1-61)

OFFICE OF THE SECRETARY OF DEFENSE

REPORT NUMBER

PROJECT NUMBER

PERFORMING ORGANIZATION NAME

ADDRESS

CITY

STATE

ZIP

REPORT NUMBER

PROJECT NUMBER

PERFORMING ORGANIZATION NAME

ADDRESS

CITY