30 1930

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

9457

PLACE OF DEATH

County Macon — Registration District No. 3-33 — File No.

Township Liberty — Primary Registration District No. 2-713 — Registered No. 23

City (No. , St. Ward)

FULL NAME John E. Skinner

(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 69 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Married

IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Lavica R. Quinkles

DATE OF BIRTH (MONTH, DAY AND YEAR) Jan-12-1861

AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	69	1	16	

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

BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Macon Co. Mo.

10. NAME OF FATHER Sidney J Skinner

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

12. MAIDEN NAME OF MOTHER Nancy Smoot

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

INFORMANT Chas O Skinner
(Address) Atlanta Mo

FILED 3/31, 1930 Mrs Luke Hunkler
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 1 1930

17. I HEREBY CERTIFY, That I attended deceased from March 2, 1930, to March, 1930 that I last saw him alive on never, 19, and that death occurred, on the date stated above, at 8 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

930 Chron. Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 908

(duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? No. DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Phys. Exam

(Signed) W. Welch, M. D

March 2, 1930 (Address) Callao Mo. Coroner

*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 Enon Cemetery — DATE OF BURIAL 3-4-1930

20. UNDERTAKER H M Goodding — ADDRESS Atlanta Mo

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. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (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. d

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

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

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

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

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)

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....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....mos.

CONTRIBUTORY .....
(SECONDARY)

.....(duration).....yrs. .....mos.

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.

, 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

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

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