

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

Do not use this space.

23704

1. PLACE OF DEATH  
 County Madison Registration District No. 619  
 Township Johnson Primary Registration District No. 437D  
 City Clairmont mo St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Rebecca Jane Skued  
 (a) Residence No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode)  
 Length of residence in city or town where death occurred 30 yrs. 5 mos. da. How long in U.S., if of foreign birth? yrs. mos. ds.

File No. \_\_\_\_\_  
 Registered No. 8  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb-23-1848

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
82 5 1

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work House wife  
 (b) General nature of industry, business, or establishment in which employed (or employer)  
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Burlington  
 (STATE OR COUNTRY) Iowa

10. NAME OF FATHER Wm Tucker

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) Unknown

14. INFORMANT C A Skued  
 (Address) Clairmont mo

15. FILED July 24 30 1930  
Aug-12-30 C. P. Dwyer REGISTRAR  
MES

**2 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 24 1930  
 17. I HEREBY CERTIFY, That I attended deceased from July 21, 1930, to July 24, 1930, that I last saw her alive on July 24, 1930, and that death occurred, on the date stated above, at 3:50 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Inflammation and obstruction of the bile ducts, by acute cholecystitis  
127B (duration) 3 yrs. 0 mos. 3 ds.  
127D CONTRIBUTORY Several previous attacks  
 (SECONDARY) Chronic (duration) 3 yrs. 0 mos. 0 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: Cholecyst  
 (Signed) W. H. Wiley, M. D.  
July 24, 1930 (Address) Clairmont 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 Clairmont Ia DATE OF BURIAL July 24 1930

20. UNDERTAKER Holler & Walker ADDRESS Bradfordville Ia

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.

1948

1948

**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 Nodaway

Registration District No. 619

File No. \_\_\_\_\_

Township \_\_\_\_\_

Primary Registration District No. 4370

Registered No. 8

City Chambers (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**

F

**4. COLOR OR RACE**

W

**5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)**

wid

**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)

**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)

PARENTS

**14.**

INFORMANT (Address) \_\_\_\_\_

**15.**

Sept 9 1930 H. H. Wiley

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

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

July 24 1930

**17.**

I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_

\_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_, and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

**THE CAUSE OF DEATH WAS AS FOLLOWS:**

Inflammation & obstruction of the bile ducts by viscid mucus

**CONTRIBUTORY (SECONDARY)**

Several previous attacks during past 3 yrs.

**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 \_\_\_\_\_

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

S-23704