

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

Do not use this space.

25883

1. PLACE OF DEATH
County Washington Registration District No. 297
Township Washington Primary Registration District No. 2016
City Washington No. _____ St. _____ Ward _____

2. FULL NAME Robert Lee Skouby
(a) Residence, No. 14th & Washington 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. 13 ds. How long in U. S., if of foreign birth? yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 4, 1932

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
			<u>13</u>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Washington Mo

13. NAME James Skouby

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Safe Mo

15. MAIDEN NAME Velva Marshall

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) West Plains Mo.

17. INFORMANT (ADDRESS) James Skouby

18. BURIAL, CREMATION, OR REMOVAL PLACE Add. Salem DATE _____ 19 _____

19. UNDERTAKER (ADDRESS) Triberg & Van Lee
Washington Mo

20. FILED Aug 17, 1932 J. S. Munn Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug. 17, 1932

22. I HEREBY CERTIFY, That I attended deceased from Aug. 18, 1932, to Aug. 17, 1932

I last saw him alive on Aug. 16, 1932. Death is said to have occurred on the date stated above, at 12:40 a.m.

The principal cause of death and related causes of importance were as follows:
Acute bronchitis

Date of onset 8/2/32

Other contributory causes of importance:
None

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify _____
(Signed) H. G. May, M. D.
(Address) Washington, Mo.

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.

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**MISSOURI STATE BOARD OF HEALTH
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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Franklin Registration District No. 297

Township Washington Primary Registration District No. 3016

City Washington (No. 1) St. Ward

2. FULL NAME Robert Lee Skowby

(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) S

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. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE Washington DATE Aug. 17 1932

19. UNDERTAKER (ADDRESS) Hiburg & Witt

20. FILED Aug 17 1932 O. L. Munch Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 17 1932

22. I HEREBY CERTIFY, That I attended deceased from to , 19

I last saw him alive on , 19 . Death is said

to have occurred on the date stated above, at m.

The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury , 19

Where did injury occur?

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) , M. D.

(Address)

SUPPLEMENTARY

N. B. 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

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