

EB 6 1939

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

2846
Do not use this space.

PLACE OF DEATH

(a) County Lafayette Registration District No. 2264
(b) Township Washington Primary Registration District No. 5626
(c) City Mayview (d) Street No. _____
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Albert C. Skidmore

(a) Residence, No. Mayview Mo. St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE white
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Georgie Skidmore - Dec.
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1st June 1882
7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
56 56 6 23
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer & Stockman
9. Industry or business in which work was done, as 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) Flemington Mo.

FATHER 13. NAME Unknown

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

MOTHER 15. MAIDEN NAME Unknown

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

17. INFORMANT (ADDRESS) Lora Tracy Mayview Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Tabor DATE Jan 26 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) A. H. Hader Higginville Mo.

20. FILED _____ 19 _____ Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 24 - 1939
22. I HEREBY CERTIFY That I attended deceased from Jan 21 - 1939, to Jan 24 - 1939. I last saw him alive on Jan 21 - 1939. Death is said to have occurred on the date stated above, at 7 A.m.
The principal cause of death and related causes of importance were as follows:

Angina Pectoris

Date of onset _____

Other contributory causes of importance: None

Name of operation None 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? No
If so, specify _____
(Signed) Robert Walling, M. D.
Mayview Mo. (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.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, _____, or by _____

Registered Apprentice No. _____, working under my personal supervision.

Signed *Robert A. Reckard*

Licensed Embalmer No. *36/37*

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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2846
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1. PLACE OF DEATH
 (a) County Lafayette Registration District No. 464
 (b) Township Washington Primary Registration District No. 3626
 (c) City _____ (d) Street No. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Albert C Skidmore
 (a) Residence, No. Magview mo. St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 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 Georgia Skidmore

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 6-1-1882

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
56 6 22

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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-24, 1939

22. I HEREBY CERTIFY, That I attended deceased from 1-21, 1939, to 1-24, 1939. I last saw him alive on 1-24, 1939. Death is said to have occurred on the date stated above, at 7 A. m.

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

Other contributory causes of importance: none

Name of operation none Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

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

FATHER 13. NAME Wm
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) mo

MOTHER 15. MAIDEN NAME Wm
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) mo

17. INFORMANT (ADDRESS) Theresa Tracy Magview mo

18. BURIAL, CREMATION OR REMOVAL PLACE St. Labor DATE 1-26, 1939

19. FUNERAL DIRECTOR (ADDRESS) A. N. Hader Higdonville mo

20. FILED 3-11-39 Wm E. M. Goodwin Local Registrar.

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 no
 (Signed) Thos B. Willis M. D.
 (Address) Magview mo

CERTIFIERS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

UNPLEASANT

