

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

22211
Do not use this space.

1. PLACE OF DEATH ²

(a) County Harrison Registration District No. 337

(b) Township Union Primary Registration District No. 5472 Registered No. _____

(c) City _____ (d) Street No. _____ St. _____
(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 SAMUEL BUTT SKINNER

(a) Residence, No. _____ 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 married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 26 1876

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<u>62</u>	<u>7</u>	<u>22</u>	<u>22</u>	

OCCUPATION 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. Stock + grain

10. Date deceased last worked at this occupation (month and year) June 1939 11. Total time (years) spent in this occupation 40

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

FATHER 13. NAME Skinner

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

MOTHER 15. MARRIED Sarah Holladay

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

17. INFORMANT (ADDRESS) Mrs. Sam Skinner Eagleville Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Hobbs DATE 6/19 39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. P. Ryan

20. FILED June 24 1939 Maria Smith Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 18 39

22. I HEREBY CERTIFY, That I attended deceased from June 12 1939 to June 18 1939
I last saw h. (m) alive on June 18 1939. Death is said to have occurred on the date stated above, at 3:30 a.m.
The principal cause of death and related causes of importance were as follows:

Hypostatic Pneumonia Date of onset 6-16-39
Cerebral Apoplexy 6-12-39

Other contributory causes of importance: 12/1
CARDIO-VASCULAR-Renal dis?

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? No
If so, specify _____
(Signed) C. W. McCarty M.D.
(Address) EAGLEVILLE - 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.

WRITE PLAINLY, WITH OUTFRINGING INK—THIS IS A PERMANENT RECORD

I X16805

RECEIVED

District Health Officer No. 10

District File Number.....739-775

Date Filed - JUL 7 1939

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.....

Licensed Embalmer No.....

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.