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X21492

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Registration District No. 398

Primary Registration District No. 5554

Registrar's No. 14

I. PLACE OF DEATH:

(a) County Jackson
(b) City or town Atchison Missouri
(c) Name of hospital or institution: Blue Township
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Not in Hospital
(Specify whether years, months or days) 20 years

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Jackson
(c) City or town Rural
(If outside city or town limit, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Offy M. Skinner

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race wh 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Emma Skinner 6. (c) Age of husband or wife if alive 65 years
7. Birth date of deceased Sep 17 1873
(Month) (Day) (Year)

8. AGE: Years 66 Months 3 Days 23 If less than one day hr. _____ min. _____

9. Birthplace Sheridan Co mo
(City, town, or county) (State or foreign country)

10. Usual occupation labor

11. Industry or business _____

MOTHER/FATHER { 12. Name James Skinner
13. Birthplace _____
14. Maiden name unknown
15. Birthplace _____

16. (a) Informant Ms Emma Skinner
(b) Address Atchison mo

17. (a) Rural (b) Date thereof Jan 13-20
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Salem Cemetery

18. (a) Signature of funeral director Off & Mitchell
(b) Address Independence mo

19. (a) Jan 13-1940 (b) F. L. Cook
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 11
year 40 hour 11 minute 17 M.

21. I hereby certify that I attended the deceased from _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Cranial fracture
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: _____
Of operations _____
Of autopsy See above

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of place)
(e) Manner of injury _____
23. Signature [Signature] (M. D. or other) _____
Address _____ Date signed 1/14/40

REGISTERED APPRENTICE
EXAMINER
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND GENERAL SERVICES
DIVISION OF LICENSING

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 me

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

Signed Henry S. Mitchell

Licensed Embalmer No. 3925

P. O. Address Andover, Md

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.

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

2595-

Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 398
(b) Township Blue Primary Registration District No. 5554 Registered No.
(c) City (d) Street No.
(If death occurred in Hospital or Institution, write its name instead of street and number) St.
(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 Ophey M Skinner

(a) Residence, No. 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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

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.
66 3 23

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
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)

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19.

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Jan 15 1940 F. L. Cook Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-11 1940

22. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....

I last saw h..... 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) C. J. Leitch, M. D.

(Address) C. J. Leitch

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

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.

Completed March 13 - 1940

