No. 2
3-40
7-39
X23159

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 38158

Registration District No. 85 NOV 19 1940

Primary Registration District No. 1001

Registrar's No. 1190

1. PLACE OF DEATH:
(a) County: Buchanan
(b) City or town: St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Joseph's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 days (Specify whether years, months or days)
In this community 7 days /

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Buchanan
(c) City or town: Rural
(If outside city or town limits, write "RURAL")
(d) Street No.: R.F.D. #6. St. Joseph, Mo. (If rural, give location)
0
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: Margaret Ann Skinner

3. (b) If veteran, name war: None

3. (c) Social Security No.: None

4. Sex: Female

5. Color or race: White

6. (a) Single, widowed, married, divorced: Widowed

6. (b) Name of husband or wife: Dr. Phene Skinner

6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased: Nov. (Month) 17 (Day) 1876 (Year)

8. AGE: Years 63 | Months 11 | Days 24 | If less than one day ____ hr. ____ min.

9. Birthplace: Buchanan County (City, town, or county) Missouri (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business: At Home 0

FATHER
12. Name: John Jones /
13. Birthplace: Unknown (City, town, or county) Ohio (State or foreign country) /

MOTHER
14. Maiden name: Mary Elizabeth Pascoe
15. Birthplace: Weston (City, town, or county) Missouri (State or foreign country)

16. (a) Informant: J. W. Jones
(b) Address: R.F.D. #6. St. Joseph, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Nov. 13. 1940 (Month) (Day) (Year)
(c) Place: burial or cremation: Memorial Park Cemetery. 85

18. (a) Signature of funeral director: H. O. Sidenfaden & Son
(b) Address: 1802 Union St. St. Joseph, Mo.

19. (a) Nov. 12, 1940 (Date received local registrar) (b) A. J. Nestlebush (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 11 th year 1940 hour 4 minute 25 A. M.

21. I hereby certify that I attended the deceased from Nov 7, 1940, to Nov 11, 1940; that I last saw her alive on Nov 10, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Nephritis — Duration: months

Due to: 54

Due to:

Other conditions: Diabetes Mellitus — months
(Include pregnancy within 3 months of death)

Major findings:
Of operations: —
Of autopsy: —

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? (Specify type of place)
While at work? 0 (e) Means of injury:

23. Signature: John E. Lynn (M. D. or other) M.D.
Address: St. Joseph, Mo. Date signed 11-11-40

(Licensed Embalmer's Statement on Reverse Side)

ST. JOSEPH

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 Albert P. Harrington

Licensed Embalmer No. 3258

P. O. Address St. Joseph, Mo

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

If this body is not embalmed, fact should be so stated above.