

FILED JAN 13 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

1717

State File No. _____

Registration District No. 72

Primary Registration District No. 4041

Registrar's No. 5

1. PLACE OF DEATH:
(a) County Boone
(b) City or town Centralia
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 50 years years, months or days

3. (a) PRINT FULL NAME HATTIE BELLE SKAGGS

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Married
(b) Name of husband or wife John Skaggs 6. (c) Age of husband 14 years
7. Birth date of deceased: 12 (Month) 14 (Day) 1970 (Year)

8. AGE: Years 70 Months 0 Days 29 If less than one day hr. _____ min. _____

9. Birthplace Bedford Co. Mo. (City, town, or county) (State or foreign country)

10. Usual occupation House Wife

11. Industry or business _____

12. Name Francis M. Traughber

13. Birthplace Logan Co. Ky. (City, town, or county) (State or foreign country)

14. Maiden name Theresa A. Bryan

15. Birthplace Boone Co. Mo. (City, town, or county) (State or foreign country)

16. (a) Informant F. Skaggs

(b) Address Centralia

17. (a) buried (b) Date thereof 1/5-1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Centralia Mo Cem

18. (a) Signature of funeral director W. McDonald

(b) Address Centralia Mo.

19. (a) 1/5/41 (b) F. H. Carden
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Boone
(c) City or town Centralia
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? 50 years years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 3rd year 1941 hour 8 minute 15 P M.

21. I hereby certify that I attended the deceased from Nov. 1940, 19____, to Jan 3, 1940; that I last saw her alive on Jan 3, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death: Acute nephritis
meningitis

Duration 5 weeks 2 days

Due to _____

Due to _____

Other conditions _____ (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? 3/5

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

23. Signature Frank W. Snyder M.D. (M. D. or other) _____

Address Centralia Mo. Date signed 1/4/41

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

0
1
0

130

DEPARTMENT OF HEALTH

STATE OF MISSOURI

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.....

M J M Donald

Licensed Embalmer No.....

2589

P. O. Address.....

Centralia Mo

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, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 1717

Registration District No. 72

Primary Registration District No. 4041

Registrar's No. 5

1. PLACE OF DEATH:

(a) County Bronx
(b) City or town Centralia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Hattie Belle Skaggs

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 70 Months 0 Days 29 If less than one day _____ hr _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) _____ (Day) _____ (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

20. DATE OF DEATH: month Jan day 3^d
year 1947 hour _____ minute _____ M.

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

Immediate cause of death Acute nephritis (infections - following flu)
Terminal Coma

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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) Means of injury _____

23. Signature J. B. Anderson (M. D. or other) _____
Address _____ Date signed _____

Duration 3 wks

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

SUPPLEMENTAL

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

MOTHER FATHER

