

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

32802

State File No.

Registrar's No. 7

Registration District No. 18

Primary Registration District No. 6139

1. PLACE OF DEATH:

(a) County Texas
 (b) City or town Rural in ...
 (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. years, months or days)

3. (a) PRINT FULL NAME Charles Edward Skelle

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

4. Sex Male 5. Color of race W 6. (a) Single, widowed, married, divorced 0

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

7. Birth date of deceased April 9 - 1944
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 4 25 hr. min.

9. Birthplace Ben Davis, Mo.
 (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name Walter Skelle

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

14. Maiden name Elmer Surtner

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

16. (a) Informant Walter Skelle

(b) Address Ben Davis

17. (a) Burial (b) Date thereof 9/13/44
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Moss

18. (a) Signature of funeral director Russell Barber

(b) Address

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Texas
 (c) City or town Rural
 (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 4
 year 1944 hour 8:30 minute P.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 Respiratory and circulatory failure 7 months after birth

Due to _____
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) 2

Major findings: Of operations 119a
 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?
 While at work? (Specify type of place) (e) Means of injury

23. Signature R A Ryan (M. D. or other) 0
 Address Moss Date signed 9/16-44

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

AVK... EM

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.

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STANDARD CERTIFICATE OF DEATH

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Registration District No. 18

Primary Registration District No. 6139

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Texas
 (b) City or town Rural
(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 _____
years, months or days

3. (a) PRINT FULL NAME Charles E. Shelle

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced _____

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

7. Birth date of deceased Apr 9 - 1944
(Month) (Day) (Year)

8. AGE: Years _____ Months 4 Days 19 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

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

14. Maiden name _____
(City, town, or county) (State or foreign country)

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Sept 10 1944 (b) Pease E. McCall
(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) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept year 1944 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 _____

Duration

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) _____

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(c) Where did injury occur? _____
(City or town) (County) (State)

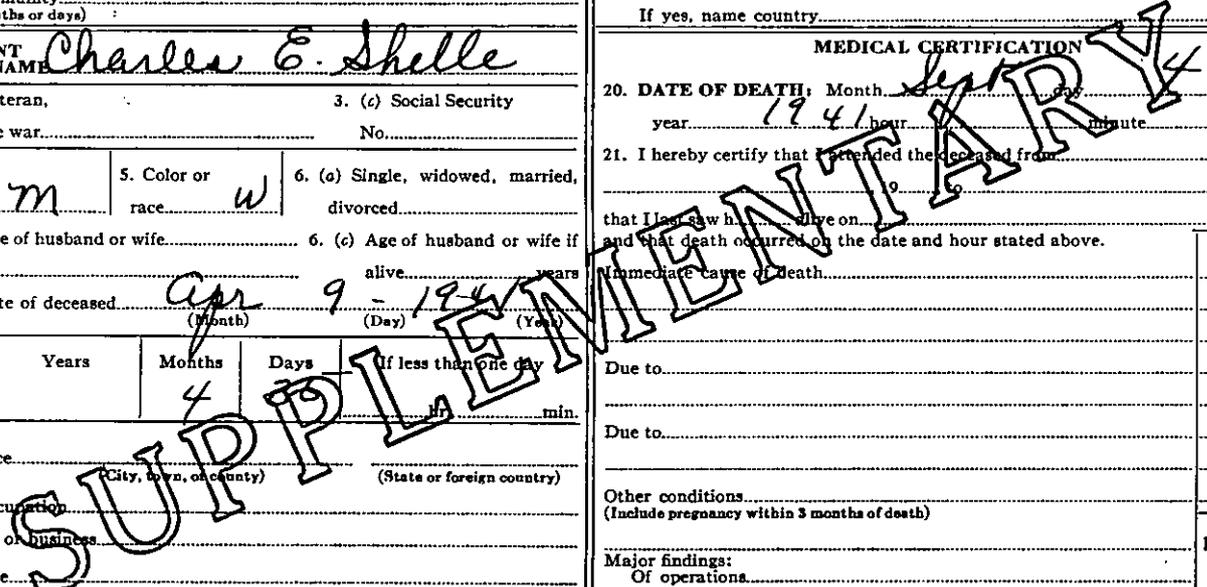
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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



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