

No. 2  
4-13-40  
5-17-40

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

FILLED NOV 8 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 34892

Registration District No. 317

Primary Registration District No. 4192

Registrar's No.

1. PLACE OF DEATH: Green  
 (a) County Republic Mo  
 (b) City or town (If outside city or town limits, write "RURAL" and name of township)  
 (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  
 In this community ~~Stillborn~~ (Specify whether years, months or days)

3. (a) PRINT FULL NAME Robert Arthur Skelton  
 3. (b) If veteran, name war  
 3. (c) Social Security No.

4. Sex Male  
 5. Color or race White  
 6. (a) Single, widowed, married, divorced Single  
 6. (b) Name of husband or wife  
 6. (c) Age of husband or wife if alive years 28  
 7. Birth date of deceased Oct 1941  
 (Month) (Day) (Year)

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

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

10. Usual occupation  
 11. Industry or business

MOTHER FATHER  
 12. Name Arthur Skelton  
 13. Birthplace Missouri Mo  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Marceline Williams  
 15. Birthplace Missouri Mo  
 (City, town, or county) (State or foreign country)

16. (a) Informant Arthur Skelton  
 (b) Address Republic Mo  
 17. (a) Evergreen (b) Date thereof Oct 29 41  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation

18. (a) Signature of funeral director R. E. Thurman  
 (b) Address Republic Mo  
 19. (a) Oct 29 (b) Mrs Bertha Namee  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo (b) County Greene Mo  
 (c) City or town Republic Mo  
 (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.?

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month ~~10~~ 10 day ~~29~~ 29  
 year 1941 hour 9:00 minute 17: M.  
 21. I hereby certify that I attended the deceased from 10-28-41  
 to 10-29-41, 1941.  
 that I last saw him alive on 10-29-41, 1941,  
 and that death occurred on the date and hour stated above.

Immediate cause of death  
 Due to unknown  
 Due to  
 Other conditions (Include pregnancy within 3 months of death)  
 Major findings: Of operations 159  
 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) (c) Means of injury  
 23. Signature (M. D. or other) D.O.  
 Address Republic Mo Date signed 10-31-41

207 (Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

Greene County Health Office,

County File Number 41-11-103

Date Filed 4/7/41

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 <sup>not</sup> my body

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

Signed R. E. Sherman

Licensed Embalmer No. 503

P. O. Address Republic, 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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **34892**

Registration District No. **317**

Primary Registration District No. **4192**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Greene  
(b) City or town Republic  
(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 Robert A Skelton

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 s

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

7. Birth date of deceased Oct 28 1941  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry of business \_\_\_\_\_

MOTHER FATHER { 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) Burial (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation Evergreen Cemetery

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) Oct. 29-41 (b) Mrs Bertha Namie  
(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 Oct Year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ 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 \_\_\_\_\_

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) \_\_\_\_\_

(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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

