7. S. No. 2
00M—5-43
ev. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 11 1944

Registration District No. 204

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 3507

Primary Registration District No. 5738

Registrar's No.

61
0
0

1. PLACE OF DEATH:
(a) County: Macon Co. Mo
(b) City or town: Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: La Plata Twp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: MACON
(c) City or town: RURAL
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country: 0

3. (a) PRINT FULL NAME: CLARENCE LEON SKAGGS
3. (b) If veteran, name war: ✓
3. (c) Social Security No. 327-05-2064
4. Sex: M
5. Color or race: W
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: ELSIE LAWSON SKAGGS
6. (c) Age of husband or wife if alive: 58 years
7. Birth date of deceased: SEPT (Month) 14 (Day) 1883 (Year)

8. AGE: Years 60 Months 4 Days 0 If less than one day hr. min.

9. Birthplace: CARLINVILLE (City, town, or county) ILL (State or foreign country)
10. Usual occupation: CENTRAL FIBRE PRODUCTS CO
11. Industry or business: QUINCY ILL LABORER
FATHER
12. Name: DELAWARE SKAGGS
13. Birthplace: Kent. (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name: SARAH MC DOWELL
15. Birthplace: Not Known (City, town, or county) (State or foreign country)
16. (a) Informant: Forest W Skaggs
(b) Address: Fowler Ill
17. (a) BURIED (Burial, cremation, or removal) (b) Date thereof: JAN 19-1944 (Month) (Day) (Year)
(c) Place: burial or cremation: GREENMOUNT
18. (a) Signature of funeral director: W S Christie
(b) Address: La Plata Mo.
19. (a) 1-19-1944 (Date received local registrar) (b) Nina Lovell (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JANUARY day 14 year 1944 hour 3 minute P.M.
21. I hereby certify that I attended the deceased from JANUARY 13, 1944, to JANUARY 14, 1944, that I last saw him alive on JANUARY 14, 1944, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic Myocarditis	1 wk.
Due to: Influenza	
Due to:	
Other conditions (Include pregnancy within 3 months of death): 93d	

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? (e) Means of injury:
23. Signature: Edward T. Merrill (M. D. or other) MD
Address: La Plata, Mo. Date signed 1/15/44

1339 (Licensed Embalmer's Statement on Reverse Side)

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 D. S. Christie

Licensed Embalmer No. 1109

P. O. Address La Plata 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.