

FILED DEC 29 1944

Primary Registration District No. 5331

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Wade

(b) City or town Jewett Springs R. 2 Cedar Twp
(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 60 years years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Wade ²⁹

(c) City or town Jewett Springs R2 Cedar Twp
(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 _____

3. (a) PRINT FULL NAME JAMES JEFFERSON SKILLEN

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 27 day Nov
year 1944 hour 2 minute 30 A.M.

4. Sex Male 5. Color or race white

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

6. (b) Name of husband or wife Elyza Jane Skillen 6. (c) Age of husband or wife if alive 78 years

7. Birth date of deceased Jan 3 1863
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov 21 1944 to Nov 27 1944 that I last saw him alive on Nov 25 1944 and that death occurred on the date and hour stated above.

8. AGE: Years 81 Months 10 Days 24 If less than one day hr. min.

Immediate cause of death Pneumonia (lobular) following influenza, from a long history of Phthisis, Tuberculosis. Duration 4 days

9. Birthplace De Witt Co. Ill.
(City, town, or county) (State or foreign country)

Due to _____

Due to _____

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

10. Usual occupation Farmer

Major findings: Of operations 13 1/2

Of autopsy _____

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

11. Industry or business _____

MOTHER FATHER { 12. Name George Skillen

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

14. Maiden name Sabel Hershaw

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

16. (a) Informant Mrs. J. J. Skillen

(b) Address Jewett Springs Mo

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? _____

17. (a) Burial (b) Date thereof Nov 28 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Newport Cem. Bartons Mo

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

18. (a) Signature of funeral director Phillips Funeral Home

(b) Address Golden City, Mo.

19. (a) Nov 28 1944 (b) Bernice M. Cooney
(Date received local register) (Registrar's signature)

23. Signature J. M. Brooks (M. D. or other) _____
Address Golden City Mo Date signed 11-27-44

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

RECEIVED

District Health Officer No. 6,

District File Number 1244-1273

Date Filed DEC 2 1944

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. 3278

P. O. Address Golden City 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.