V. S. No. 2
DM—9-4-41
Rev. 5-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 7 1945

Registration District No. 149

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 5329

Primary Registration District No. 1002

Registrar's No. 911

1. PLACE OF DEATH:
(a) County: Jackson
(b) City or town: Kansas
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Research O
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 12 hr 10" (Specify whether years, months or days)
In this community: 12 hr 10"

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jackson
(c) City or town: Kansas
(If outside city or town limits, write "RURAL")
(d) Street No.: 3325 Chestnut
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: O

3. (a) PRINT FULL NAME: Joseph Skinner

3. (b) If veteran, name war: no

3. (c) Social Security No.: none

4. Sex: Male O

5. Color or race: W

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

6. (b) Name of husband or wife: —

6. (c) Age of husband or wife if alive: — years

7. Birth date of deceased: 2 - 2 - 45 (Month) (Day) (Year)

8. AGE: Years | Months | Days | If less than one day: 12 hr. 10 min.

9. Birthplace: Kansas City (City, town, or county) Missouri (State or foreign country)

10. Usual occupation: infant

11. Industry or business:

MOTHER FATHER

12. Name: Andrew Earl Skinner

13. Birthplace: Kansas city (City, town, or county) missouri (State or foreign country)

14. Maiden name: Mary Rose Rockers

15. Birthplace: Creeley K (City, town, or county) Kansas (State or foreign country)

16. (a) Informant: Mrs Skinner
(b) Address: 3325 Charlotte

17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof: 2-5-45 (Month) (Day) (Year)
(c) ~~Place of burial or cremation~~: Research Hospital

18. (a) Signature of funeral director: " "
(b) Address: K. C. Mo.

19. (a) 2-14-45 (Date received local registrar) (b) N. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 2 year 45 hour 6 AM minute M.

21. I hereby certify that I attended the deceased from February 2, 1945, to Feb 2, 1945 that I last saw h. l. m. alive on Feb 2, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Prematurity

Due to: Twin-delivery

Due to: —

Other conditions (Include pregnancy within 3 months of death): —

Major findings:
Of operations: 159

Of autopsy: —

Duration

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: O

23. Signature: [illegible] (M. D. or other)
Address: 3850 Prospect Date signed: 2-21-45

(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.....

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, fact should be so stated above.