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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 14 '945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **17420**
Registrar's No. **7878**

Registration District No. **157** Primary Registration District No. **3040**

1. PLACE OF DEATH:
(a) County Linn
(b) City or town Clidicott
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1521 Clay St.
(If not in hospital or institution, write street number or location) 1
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community 5 months (years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Madison
(c) City or town Brasher
(If outside city or town limits, write "RURAL") 0
(d) Street No. _____ (If rural, give location) _____
(e) Citizen of foreign country? No (Yes or No) 1
If yes, name country _____

3. (a) PRINT FULL NAME Susan Skinner
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May day 31 year 1945 hour 1 minute _____ P. M.
21. I hereby certify that I attended the deceased from May 31 1945 to May 30 1945
that I last saw her alive on May 31 1945 and that death occurred on the date and how stated above.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Henry Skinner 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased April 3, 1858 (Month) (Day) (Year)

Immediate cause of death apoplexy Duration 2 days
Due to: Hypertension ?

8. AGE:	Years	Months	Days	If less than one day
	<u>87</u>	<u>1</u>	<u>28</u>	<u>—</u> hr. <u>—</u> min.

Due to _____
Other conditions (include pregnancy within 3 months of death) §301

9. Birthplace Lebanon, Kansas (City, town, or county) (State or foreign country)
10. Usual occupation at home

Major findings: Of operations _____
Of autopsy _____
PHYSICIAN
Underline the cause to which death should be charged statistically.

11. Industry or business _____
12. Name William J. Stewart
13. Birthplace Lebanon, Mo. (City, town, or county) (State or foreign country) 9
14. Maiden name Leticia Sears
15. Birthplace Unknown (City, town, or county) (State or foreign country) 9

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? _____

16. (a) Informant Mrs. Fred Waddy
(b) Address Linn, Mo.
17. (a) Burial (b) Date thereof 6/2/45 (Month) (Day) (Year)
(c) Place: burial or cremation Brasher, Mo.

While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature P. Brennan (M. D. _____)
Address Clidicott, Mo. Date signed May 31-45

18. (a) Signature of funeral director Earley Workman & Co.
(b) Address Brasher, Missouri
19. (a) _____ (b) _____ (Registrar's signature)
(Date received local registrar)

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

RECEIVED

District Health Officer No. 11,

District File Number.....

Date Filed.....

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.....

Ronald F. Jordan

Licensed Embalmer No. *4191*

P. O. Address *Chillicothe, 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.

Registration District No. 187 Primary Registration District No. 3040

1. PLACE OF DEATH:
(a) County Livingston
(b) City or town Chellie Cothran
(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 _____ (Specify whether _____)
years, months or days)

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 _____

3. (a) PRINT FULL NAME Susan Skinner
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May year 1945 at _____ M.
21. I hereby certify that I reached the deceased from _____, 19____;
that I last saw him/her alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Apr. 3 (Month) (Day) (Year)

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.

8. AGE: Years 87 Months 1 Days _____ (Unless than one day) min. _____

9. Birthplace Leura (City, town, or county) (State or foreign country)
10. Usual occupation _____
11. Industry or business _____
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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) (Place: burial or cremation)
18. (a) Signature of funeral director _____ (b) Address _____

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) _____
Date signed _____

19. (a) May 31 (b) Lowella Curry
(Date received local registrar) (Registrar's signature)

SUPPLEMENTARY

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

MOTHER FATHER

17420