

FILED NOV 23 1945

Registration District No.

Primary Registration District No. 5392

Registrar's No. 57

1. PLACE OF DEATH:

(a) County Dent

(b) City or town Watkins Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
X
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution X (Specify whether
years, months or days)

In this community about 12 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dent 33

(c) City or town Rural 0
(If outside city or town limits, write "RURAL")

(d) Street No. X (If rural, give location) 0

(e) Citizen of foreign country? X (Yes or No) 0

If yes, name country X

3. (a) PRINT FULL NAME John A Skiles

3. (b) If veteran, name war X

3. (c) Social Security No. X

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 30
year 1945 hour 7 minute 30 P.M.

4. Sex male 5. Color or race W

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

6. (b) Name of husband or wife Mary Cox Skiles

6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased: Oct 10 1861
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 1941 19to 9-30-45 19;
that I last saw him alive on 9-10-45 19;
and that death occurred on the date and hour stated above.

8. AGE: 83 Years 11 Months 20 Days
If less than one day
hr. min.

Immediate cause of death central arteriosclerosis
hypertensive vascular disease

Due to 10 yrs.

Due to 10 yrs.

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

10. Usual occupation farmer

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations 97

Of autopsy

MOTHER FATHER

11. Industry or business X

12. Name Isabel Skiles

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

14. Maiden name Polly Hobson

15. Birthplace Dent Co Mo
(City, town, or county) (State or foreign country)

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. George Frank, Jr

(b) Address Lenox Mo

17. (a) burial (b) Date thereof 10/2/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Herman

18. (a) Signature of funeral director Carl J. Jones

(b) Address Salem Mo

19. (a) 10-3-45 (b) M. M. Hunt, M.D.
(Date received local registrar) (Registrar's signature)

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 J. D. Hunt (M. D. or other) D.O.

Address Salem Mo Date signed 10-1-45

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

RECEIVED

District Health Officer No. 5

District File Number. 1145-513

Date Filed 11-9-45

NOV 19 1945

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

Carl H. Johnson

Licensed Embalmer No.

2320
John M.

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *hw*

Registrar's No. *57*

Registration District No. *100*

Primary Registration District No. *5392*

1. PLACE OF DEATH:

(a) County *Mont.*
(b) City or town *Rural Wathensburg*
(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

John A. Skiles

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.....

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

7. Birth date of deceased *Oct 10 1961*
(Month) (Day) (Year)

8. AGE: Years *83* Months *11* Days *14* If less than one day..... hr. min.

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

10. Usual occupation.....

11. Industry or 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, cremation, or removal)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a) (Date received local registrar)..... (b) (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 *10* Day *14* Year *1961* hour *12* minute *00* M.

21. I hereby certify that I attended the deceased from *10/10/61* to *10/14/61*, 19.....
that I last saw him alive on *10/14/61* 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

33660