

X37823

Registration District No. 140

Primary Registration District No. 3024

1. PLACE OF DEATH:

(a) County Howard
(b) City or town Fayette
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Lee Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 weeks
In this community Most of her life
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howard
(c) City or town Fayette
(If outside city or town limits, write "RURAL")
(d) Street No. 305 W. Morrison
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME Amanda Elizabeth Griffin Skillman

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

20. DATE OF DEATH: Month October day 19th
year 1946 hour 10:00 minute P. M.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced, Widowed
6. (b) Name of husband or wife Marion Grant Skillman 6. (c) Age of husband or wife if alive years
7. Birth date of deceased: January 15th 1865
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan. 1946 to Oct. 19, 1946
that I last saw her alive on Oct 19, 1946, and that death occurred on the date and hour stated above.

Immediate cause of death: Acute pulmonary edema Duration 6 hrs.
Due to Ca of heart with metastases 6 yrs.
Due to _____

8. AGE: Years Months Days If less than one day
81 9 4 hr. min.

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

9. Birthplace: Ohio (City, town, or county) (State or foreign country)
10. Usual occupation: At Home

Major findings: Of operations 50
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

11. Industry or business _____
12. Name Samuel Griffin
13. Birthplace Ohio
(City, town, or county) (State or foreign country)
14. Maiden name Prima Wilcoxin
15. Birthplace Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Miles Skillman
(b) Address Fayette, Missouri
17. (a) Burial (b) Date thereof 10/21/46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation: Fayette City Cemetery

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 0

18. (a) Signature of funeral director: Ralph A. Carr
(b) Address Fayette, Missouri
19. (a) 10-26-1946 (b) Dorothy J. ...
(Date received local registrar) (If not a signature)

23. Signature Wm J Shaw (M. D. or other) MP.
Address Fayette Mo. Date signed 10-23-46

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

MOTHER FATHER

123

RECEIVED

District Health Officer No. 8.

District File Number _____

Date Filed 11-2-46

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 ~~and~~ _____

_____, Registered Apprentice No. _____,
working under my personal supervision.

Signed Ralph A. Carr

Licensed Embalmer No. 3340

P. O. Address Jayette 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.