

Registration District No. **42**

Primary Registration District No. **1000**

Registrar's No. **1365**

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

**1. PLACE OF DEATH:**

(a) County Buchanan

(b) City or town St. Joseph

(c) Name of hospital or institution: State Hospital #2  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 16 yrs 7 mo 1 day  
In this community 16 years, 7 months, 1 day  
(years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State MO (b) County Jackson

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

(d) Street No. 4138 Raytown Rd  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME:** Oscar M. Skankasville

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

4. Sex MO 5. Color or race N 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Amelia 6. (c) Age of husband or wife if alive not stated years

7. Birth date of deceased: Nov 19 1876  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>70</u>	<u>0</u>	<u>19</u>	hr. min.

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

10. Usual occupation laborer

**MOTHER FATHER**

11. Industry or business \_\_\_\_\_

12. Name James Statesville

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

14. Maiden name Estimate J. Brown

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

16. (a) Informant Amelia Skankasville

(b) Address 4138 Raytown Rd

17. (a) removal (b) Date thereof 12/10/46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Stanley Kans

18. (a) Signature of funeral director Mrs. L. H. Fowler

(b) Address 218 Washburn Ave, Mo

19. (a) Dec. 9, 1946 (b) E. C. Jenkins  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Dec day 8 year 1946 hour 7 minute 9 M.

21. I hereby certify that I attended the deceased from Nov 7/46 1946 to Dec 8 1946 that I last saw him alive on Dec 7 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage

Due to Epilepsy

Other conditions (include pregnancy within 3 months of death) 83A

Major findings: Of operations \_\_\_\_\_ Of autopsy \_\_\_\_\_

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 E. C. Jenkins (M. D. or other) \_\_\_\_\_  
Address State Hosp #2 Date signed 12/10/46

Duration 1 hr

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

MAY 8 1954

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 C. H. Neise  
Licensed Embalmer No. 3570  
P. O. Address Kansas 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.