

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

1. PLACE OF DEATH:

(a) County Nodaway

(b) City or town Maryville, Mo.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Francis Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 Weeks  
(Specify whether years, months or days)

In this community 47 Years

3. (a) PRINT FULL NAME CLAUDE ADELBERT SKEED

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Myrtle May Skeed

6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased August 26, 1885  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

61 8 25 hr. -- min.

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

10. Usual occupation Farmer

11. Industry or business None

MOTHER FATHER { 12. Name Adelbert P. Skeed

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

14. Maiden name Florence Lanning

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

16. (a), Informant Myrtle May Skeed

(b) Address Clearmont, Mo.

17. (a) Burial (b) Date thereof 5/23/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Clearmont, Mo.

18. (a) Signature of funeral director Pine Funeral home

(b) Address 120 East 1st, Maryville, Mo.

19. (a) 5/21/47 (b) Beas Holt  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Nodaway

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

(d) Street No. 1 1/2 Miles South  
(If rural, give location)

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

If yes, name country None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 21st  
year 1947 hour 11 minute 30 A.M.

21. I hereby certify that I attended the deceased from May 5, 1947, to May 21, 1947  
that I last saw him alive on May 21, 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral & Respiratory Paralysis

Due to Cerebral Hemorrhage - 2nd lumen

Diagnosis: Senescent Arteriosclerosis, Hypertension, Diabetes Mellitus

Other conditions Diabetes Mellitus - years

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

Of autopsy U

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 U

23. Signature W. J. ... (M. D. or other) \_\_\_\_\_

Address Maryville, Mo. Date signed 5-22-47

**DISTRICT HEALTH OFFICE  
Cameron, Mo.**

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**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..... *W. L. Gee* .....

Licensed Embalmer No. *2539* .....

P. O. Address..... *Marionville 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.**