No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 36271

FILED OCT 24 1947 318 1003

Registration District No. ..... Primary Registration District No. ..... Registrar's No. 9578

1. PLACE OF DEATH:
(a) County .....
(b) City or town ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution 4953 ARSENAL ST
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community .....

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County 000
(c) City or town ST. LOUIS 17
(If outside city or town limits, write "RURAL")
(d) Street No. 4953 ARSENAL ST 9
(If rural, give location) 0
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME MARY E. SKILLMAN
3. (b) If veteran, name war .....
3. (c) Social Security No. .....
4. Sex FE 1
5. Color or race W.
6. (a) ~~Single,~~ widowed, ~~married,~~ ~~divorced~~ WIDOW 2
6. (b) Name of husband or wife RICHARD SKILLMAN
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased NOVEMBER (Month) 18 (Day) 1859 (Year)

8. AGE: Years 87 Months 10 Days 27 If less than one day ..... hr. ..... min.

9. Birthplace HARDENSBURG, KY (City, town, or county) (State or foreign country)
10. Usual occupation .....
11. Industry or business NIL
MOTHER FATHER
12. Name MARTIN WEATHERFORD
13. Birthplace KENTUCKY (City, town, or county) (State or foreign country)
14. Maiden name MELINDA BEARD
15. Birthplace KENTUCKY (City, town, or county) (State or foreign country)
16. (a) Informant Mrs Joseph Skillman
(b) Address 4953 ARSENAL
17. (a) REMOVAL (Burial, ~~cremation, or removal~~) (b) Date thereof Oct 16-47 (Month) (Day) (Year)
(c) Place: burial ~~or cremation~~ CLOVER Port. Ky.
18. (a) Signature of funeral director E. J. Schnur
(b) Address 3125 Lafayette Av
19. (a) OCT 16 1947 (Date received local registrar) (b) J. F. Brecher (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 15 year 1947 hour 3 minute 15 A.M.
21. I hereby certify that I attended the deceased from Sept 2, 1947 to Oct 15, 1947 that I last saw her alive on Oct 15, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Carcinoma ascending colon	6 mo
Due to —	
Due to —	
Other conditions none (Include pregnancy within 3 months of death)	

Major findings:
Of operations .....
Of autopsy none

PHYSICIAN — Underline the cause of 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) 0
While at work? ..... (e) Means of injury .....
23. Signature Victor E. Schermer (M. D. or other) MD
Address 3720 Washington Blvd Date signed 10-15-47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

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 Jos B Vollmer

Licensed Embalmer No. 4014

P. O. Address 3125 Lafayette

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.