

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED FEB 11 1948

Registration District No. _____

Primary Registration District No. 3056

Registrar's No. 42

1. PLACE OF DEATH:

(a) County Randolph
(b) City or town Moberly
(If outside city or town limits, write "RURAL", and name of township)
(c) Name of hospital or institution: McCormick Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 hours
(Specify whether years, months or days)
In this community 2 months + 4 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Randolph
(c) City or town Moberly Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 1613 Schueman
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME CAROLINE ANN SKINNER

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased November - 26 - 1947
(Month) (Day) (Year)

8. AGE: Years 0 Months 2 Days 4 If less than one day _____ hr. _____ min.

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

10. Usual occupation Infant

11. Industry or business _____

MOTHER FATHER { 12. Name Otha Lee Skinner
13. Birthplace Bevier Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Grace Wata Crockett
15. Birthplace Jeffersonville Indiana
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Otha L. Skinner

(b) Address 1613 Schueman Moberly Mo

17. (a) Burial (b) Date thereof Feb - 1 - 48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Java Creek Cemetery

18. (a) Signature of funeral director Howe Funeral Home

(b) Address Moberly Missouri

19. (a) 2-1-48 (b) Leah Villaveau-Jou
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 30
year 1948 hour 2 minute 30 P.M.

21. I hereby certify that I attended the deceased from 1-30-48
_____, 19____, to 1-30-48, 19____;

that I last saw her alive on 1-30-48, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Duration 3 days

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____ Of autopsy _____
Underline the cause to which death should be attributed statistically.
107
SUPPLEMENTARY INFORMATION REQUESTED

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 2

23. Signature W. H. McCormick D.O. (M. D. or other) _____
Address 3005 Red St. Moberly MO Date signed 1-30-48

WRITE PLAINLY - USE UNFADING INK - MAKE PERMANENT RECORD

N. B. - Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED
District No. 2-48-268
FEB -9 1948

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.

*Infant
Not Embalmed*

Signed.....

Licensed Embalmer No.....

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, above space should be left blank.

Registration District No. 294

Primary Registration District No. 3056

1. PLACE OF DEATH

(a) County Randolph
(b) City or town Moberly
(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

Caroline A. Skinner

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S.

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

7. Birth date of deceased Nov. 26
(Month) (Day) (Year)

8. AGE: Years 6 Months Days 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

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 12 Year 1948 hour minute M.

21. I hereby certify that I attended the deceased from 10 to 10, 1948; that I last saw him alive on 12, 1948; and that death occurred on the date and hour stated above. Immediate cause of death Pneumonia

Due to 2 Days

Due to

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations 109A
Of autopsy

Duration
2 Days
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) (c) Means of injury
23. Signature W. H. M. Cornish D.D. (M.D. or other)
Address 500 1/2 Reed St. Moberly Mo. Date signed

SUPPLEMENTARY

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

S-2099

200

Bill

10/11