

No. 300
10.48

FILED MAR 3 1949

THE DIVISION OF HEALTH OF MASSACHUSETTS
STANDARD CERTIFICATE OF DEATH

4443

State File No.

BIRTH NO. _____ REG. DIST. NO. 104 PRIMARY REG. DIST. NO. 4176 Registrar's No. 10

1. PLACE OF DEATH a. COUNTY <u>Dunklin</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Dunklin</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Malden</u>	c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) <u>Campbell</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Home</u>		d. STREET ADDRESS (If rural, give location) <u>Home</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Henry</u>	b. (Middle) <u>Monroe</u>	c. (Last) <u>Skidmore</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 14 1949</u>
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5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married (Dec)</u>	8. DATE OF BIRTH <u>June 27, 1863</u>	9. AGE (In years last birthday) <u>83</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	11. BIRTHPLACE (State or foreign country) <u>MO</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>John Skidmore</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Royal</u>	14. NAME OF HUSBAND OR WIFE <u>Martha Skidmore</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Cora B Crawford Campbell</u>	ADDRESS <u>Campbell</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocarditis - sclerosis of</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Corinary arteries.</u> DUE TO (c) <u>General Arterial sclerosis</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Dementia due to Brown Sclerosis</u>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>H201</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <input checked="" type="checkbox"/>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>✓</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Feb 13, 1949, to Feb 14, 1949 that I last saw the deceased alive on Feb 14, 1949, and that death occurred at 12 noon from the causes and on the date stated above.

23a. SIGNATURE <u>S. C. Cullerton</u>	(Degree or title) <u>D.O.</u>	23b. ADDRESS <u>Malden Mo</u>	23c. DATE SIGNED <u>2-14-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>2-16-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Campbell</u>	24d. LOCATION (City, town, or county) (State) <u>Campbell Mo.</u>
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DATE REC'D BY LOCAL REG. <u>Feb 23, 1949</u>	REGISTRAR'S SIGNATURE <u>J. S. Scherman</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Deby</u>	ADDRESS <u>Rector Ark</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Office No. 2

District File Number 249-311

Date Filed 2-28-49

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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.....

..... Student Embalmer No.

working under my personal supervision.

Signed.....

Signed.....
Student Embalmer

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, fact should be so stated above.