

FILED FEB 17 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6753

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1116**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4117 Cleveland		d. STREET ADDRESS (If rural, give location) 4117 Cleveland	

3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
a. (First) Atchison B.	b. (Middle) Skipwith	(Month) Feb.	(Day) 1, (Year) 1950

5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Jun. 5, 1861	9. AGE (In years last birthday) 88	IF UNDER 1 YEAR Months	IF UNDER 4 WKS. Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Tennessee	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME Unk Skipwith	13b. MOTHER'S MAIDEN NAME unk	14. NAME OF HUSBAND OR WIFE ANNA SKIPWITH
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) none (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Matilda A. Skipwith	ADDRESS 4117 Cleveland
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Sclerosis Arteriosclerotic		2
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic Myocarditis Chronic Bronchitis DUE TO (c) Prostatic Hypertrophy		2
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		Seminal	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 4221
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	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 **Oct 24, 1942** to **Feb 1, 1950**, that I last saw the deceased alive on **Feb 1, 1950**, and that death occurred at **12 noon**, from the causes and on the date stated above.

23a. SIGNATURE St Louis Schuchat, M.D. (Degree or title)	23b. ADDRESS 3866 Polara Place	23c. DATE SIGNED 2-3-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 2-4-50	24c. NAME OF CEMETERY OR CREMATORY St. Matthews	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL FEB 4 1950	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE Southern Funeral Home	ADDRESS 6322 S. Grand Blvd.,
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. Schuchat
3866 Flora

11 A.M. Fri.

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.

Student
Student Embalmer

Signed

David Van Horn

Licensed Embalmer No. 4242

P. O. Address 6322 So Grand

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.