

FILED MAY 1 1950

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. **15009**  
 Registrar's No. **3596**

BIRTH NO. **76807-49** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <b>St. Louis</b> )		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b> <b>2190</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Johns Hospital</b>		STREET ADDRESS (If rural, give location) <b>4128 West Pine Blvd.</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Linda</b>	b. (Middle) <b>Sue</b>	c. (Last) <b>Skeeters</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>4-18-50</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never Married</b>	8. DATE OF BIRTH <b>Nov. 6, 1949</b>	9. AGE (In years last birthday) <b>5</b>	IF UNDER 1 YEAR Months <b>5</b> Days	IF UNDER 1 HR. Hours <b>0</b> Min.
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10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <b>Baby</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>St. Louis, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Clifford Skeeters</b>	13b. MOTHER'S MAIDEN NAME <b>Lucille Murray</b>	14. NAME OF HUSBAND OR WIFE <b>Never Married</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Clifford Skeeters</b>	ADDRESS <b>4128 West Pine Blvd.</b>
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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 <b>?</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>St. Status Lymphaticus</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION <b>4/18/50</b>	19b. MAJOR FINDINGS OF OPERATION <b>Cavernous Angioma of scalp (same kind)</b>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) <b>275th</b>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <b>1:00 p.m.</b>	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 **4/18**, 19**50**, to **4/18**, 19**50**, that I last saw the deceased alive on **4/18**, 19**50**, and that death occurred at **11:45 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Thomas M. Martin M.D.</b>	23b. ADDRESS <b>634 No Grand Bul</b>	23c. DATE SIGNED <b>4-19-50</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>4-20-50</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Normandy Missouri</b>
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DATE REC'D BY LOCAL REG. <b>APR 19 1950</b>	REGISTRAR'S SIGNATURE <b>J. B. Pascoe</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Albert H. Hoppe</b>	ADDRESS <b>4700 Washington</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed \_\_\_\_\_

*Palmer H. Palmer*

Signed.....

Student Embalmer

Licensed Embalmer No. *407*

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.