

FILED OCT 9 1950

STANDARD CERTIFICATE OF DEATH

State File No. 31502

BIRTH NO. 124 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 6075 Registrar's No. 324

1. PLACE OF DEATH a. COUNTY St. Francois		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY City of St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Farmington RURAL St. Francois		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 4451 Russell	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Missouri State Hospital No. 4			

3. NAME OF DECEASED (Type or Print)	a. (First) CLARENCE	b. (Middle) GUTTMANN	c. (Last) SKINNER	4. DATE OF DEATH (Month) (Day) (Year) Sept. 28, 1950
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 29, 1909	9. AGE (In years last birthday) 41
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales engineer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME F. A. C. Skinner	13b. MOTHER'S MAIDEN NAME Clara Guttman	14. NAME OF HUSBAND OR WIFE Dorothy Henkel
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown	16. SOCIAL SECURITY NO. 176017970	17. INFORMANT'S SIGNATURE OR NAME Records State Hospital No. 4, Farmington, Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* Brain tumor - - - malignant - - - (supp. report)	Unknown.		Abt. 5 mos.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 23, 1950 to Sept. 28, 1950, that I last saw the deceased alive on Sept. 28, 1950, and that death occurred at 5:30A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) John A. Brennan, M.D. (1)	23b. ADDRESS State Hospital No. 4, Farmington, Mo.	23c. DATE SIGNED 9-29-50
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9-30-50	24c. NAME OF CEMETERY OR CREMATORY Laurel Hill Gardens
		24d. LOCATION (City, town, or county) (State) St. Louis County, Mo

DATE REC'D BY LOCAL REG. Sept. 29, 1950	REGISTRAR'S SIGNATURE Ether Rudloff	25. FUNERAL DIRECTOR'S SIGNATURE Calvin Feutz	ADDRESS 4828 Nat'l. Bridge, St. Louis Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

20

File No. _____
DISTRICT HEALTH OFFICE No. 4

OCT - 2 1950

RECEIVED

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.....
Student Embalmer

Signed.....

Paul K. Regal

Licensed Embalmer No. 4120

P. O. Address Farmington Me

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.