

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32394

FILED SEP 26 1950

State File No. 4521

BIRTH NO. 55312-50 REG. DIST. NO. 356 PRIMARY REG. DIST. NO. 6209 Registrar's No. 23

1. PLACE OF DEATH a. COUNTY <u>Texas</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>Texas</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Houston</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural - OZARK</u>	
c. LENGTH OF STAY (in this place) <u>2 hrs</u>		1070	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Dr Kramer's Office.</u>		d. STREET ADDRESS (If rural, give location) <u>SE. Houston MO.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>CLARENCE</u> b. (Middle) <u>MARVIN</u> c. (Last) <u>SKAGGS</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>9 3 50</u>		
5. SEX <u>MO</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>N.M.</u>	8. DATE OF BIRTH <u>9-3-50</u>	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months <u>2</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>

13a. FATHER'S NAME <u>CLARENCE SKAGGS</u>		13b. MOTHER'S MAIDEN NAME <u>Orfa Smith</u>		14. NAME OF HUSBAND OR WIFE <u>none</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Orfa SKAGGS</u> ADDRESS <u>HOUSTON, MO.</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Asphyxia neonatorum</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2</u>	
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES	
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <u>Prematurity (21wks)</u>	
DUE TO (c) <u>Premature separation Placenta.</u>		7615	
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing 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) <u>—</u>		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) m.		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 9-3, 1950 to 9-4, 1950, that I last saw the deceased alive on 9-4, 1950, and that death occurred at 12:10 AM, from the causes and on the date stated above.

23a. SIGNATURE <u>Scott J. Kramer M.D.</u> (Degree or title)		23b. ADDRESS <u>Houston, MO.</u>		23c. DATE SIGNED <u>9-4-50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>9-4-50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Union Chapel</u>	
24d. LOCATION (City, town, or county) (State) <u>Texas Co. MO.</u>					

DATE REC'D BY LOCAL REG. <u>9-9-50</u>		REGISTRAR'S SIGNATURE <u>Myrtle Craig</u> 327		25. FUNERAL DIRECTOR'S SIGNATURE <u>Rayford O. Elliott</u> ADDRESS <u>Houston MO.</u>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

DIVISION OF HEALTH OF MO.
District No. 5 - Springfield

RECEIVED SEP 18 1950

Dist. File 950-1945

Date Filed 9-23-50

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 _____

No Embalming

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

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, fact should be so stated above.