

FILED APR 3 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 11156

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 711

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give town) NORMANDY		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis-2269	
d. FULL NAME OF HOSPITAL OR INSTITUTION Penn Home Nursing		STREET ADDRESS (If rural, give location) 2807 N. 9th. St	

3. NAME OF DECEASED (Type or Print) a. (First) Francis b. (Middle) M. c. (Last) Skaggs		4. DATE OF DEATH (Month) (Day) (Year) 3 18 51	
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Jan. 13th. 1867
9. AGE (In years last birthday) 84		10. 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) Missouri		12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME Abram Skaggs	13b. MOTHER'S MAIDEN NAME Margaret Drenen	14. NAME OF HUSBAND OR WIFE late Annie Skaggs
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. no	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Leona Mathis 2412 S. Broadway
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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 1 wk
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage thrombosis		unknown
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic Cardiovascular disease		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 1 Cachexia 2 Cardiac hypertrophy			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION 422.1	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) _____
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input checked="" 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 4, 1951**, to **March 18, 1951**, that I last saw the deceased alive on **March 15, 1951**, and that death occurred at **4:40 a.m.**, from the causes and on the date stated above.

22a. SIGNATURE Lewis A. Luttman MD (Degree or title)	23b. ADDRESS 8231 Clayton Rd (17)	23c. DATE SIGNED 3/19/51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3-21-51	24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cem.	24d. LOCATION (City, town, or county) (State) St. Lo is County Mo
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DATE RECD BY LOCAL REG. 3/19/51	REGISTRAR'S SIGNATURE Herbert R. Danks	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Leidner U. 2223 St. Louis Ave.
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(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10-58
4

8131

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.....

John J. Laine

Signed.....

Student Embalmer

Licensed Embalmer No. *4108*

P. O. Address *St. Louis Mo*

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.