

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9076**

FILED APR 15 1952

BIRTH NO. _____ REG. DIST. NO. **207** PRIMARY REG. DIST. NO. **5756** Registrar's No. **13**

1630
1

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

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY MARIES | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY MARIES | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL (JEFFERSON TWN) | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL (JEFFERSON TOWNSHIP) | |
| c. LENGTH OF STAY (In this place) entire | | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address and location) family home | | d. STREET ADDRESS (If rural, give location) 0630 1 | |

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|---|-------------------------------|--|--|--|-----------------------------------|--|
| 3. NAME OF DECEASED (Type or Print) a. (First) JERNSEN b. (Middle) PETER c. (Last) SKOUBY | | | 4. DATE OF DEATH (Month) (Day) (Year) April 6-1952 | | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED | 8. DATE OF BIRTH JAN 1st 1886 | 9. AGE (In years last birthday) 66 | IF UNDER 1 YEAR Months Days | IF UNDER 4 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING | | 10b. KIND OF BUSINESS OR INDUSTRY OWN FARM | | 11. BIRTHPLACE (State or foreign country) MISSOURI | | 12. CITIZEN OF WHAT COUNTRY? USA |

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|---|--|---|--|--|--|
| 13a. FATHER'S NAME PETER SKOUBY | | 13b. MOTHER'S MAIDEN NAME MARIES JESSEN | | 14. NAME OF HUSBAND OR WIFE OTTIE SKOUBY | |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS MRS. OTTIE SKOUBY - BELLE, MO. | |
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| 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* (a) Cerebral Hemorrhage | | | | 5 days | |
| * This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. | | ANTECEDENT CAUSES | | | |
| | | 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. | | | |

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|------------------------|--|----------------------------------|--|---|--|
| 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) 331X | |
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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? |
|--|--|--|--|--|----------------------------|

22. I hereby certify that I attended the deceased from **Mar 1, 1952**, to **Mar 6, 1952**, that I last saw the deceased alive on **Mar 5, 1952**, and that death occurred at **1:20 p.m.**, from the causes and on the date stated above.

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| 23a. SIGNATURE (Degree or title) R. A. Schoenholz, D.D. | | 23b. ADDRESS Belle, Mo. | | 23c. DATE SIGNED 4/7/52 | |
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| 24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 24b. DATE 4/8/52 | | 24c. NAME OF CEMETERY OR CREMATORY HIGHGATE CEMETERY | | 24d. LOCATION (City, town, or county) (State) (MARIES COUNTY, MO.) | |
|--|--|----------------------------|--|--|--|--|--|

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|---|--|--|--|--|--|-------------------------|--|
| DATE REC'D BY LOCAL REG. 4-8-52 | | REGISTRAR'S SIGNATURE Pauline Howard | | 25. FUNERAL DIRECTOR'S SIGNATURE SAS SHANN'S FUNERAL SERVICE | | ADDRESS BELLE | |
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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Chester Garrison

Licensed Embalmer No. 4128

P. O. Address Blad-hu.

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.