

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **28203**

FILED **SEP 11 1953**

BIRTH NO. _____		REG. DIST. NO. 107		PRIMARY REG. DIST. NO. 3019		Registrar's No. 99	
1. PLACE OF DEATH a. COUNTY DUNKLIN				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death) a. STATE MO. b. COUNTY DUNKLIN			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kennett		c. LENGTH OF STAY (In this place) 1 Day		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN arbyrd Mo 0350		d. STREET ADDRESS (If rural, give location) 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION Dunklin Co. Memorial Hosp				3. NAME OF DECEASED a. (First) Samuel b. (Middle) Lewis c. (Last) SKELTON			
4. DATE OF DEATH (Month) (Day) (Year) Aug. 21 1953		5. SEX M		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH Sept 9, 1892		9. AGE (In years last birthday) 61		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Mo.		12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Lewis Skelton		13b. MOTHER'S MAIDEN NAME Talitha Hodge	
14. NAME OF HUSBAND OR WIFE Lucy Skelton		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Lucy Skelton arbyrd mo	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hematemesis due to esophageal varices ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Due to (b) Hepatic Cirrhosis DUE TO (c) 5810 II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Myocardial insufficiency				INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs	
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) (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 Aug 20, 1953 to Aug 21, 1953 , that I last saw the deceased alive on Aug 21, 1953 , and that death occurred at 9:05 P.M. , from the causes and on the date stated above.							
23a. SIGNATURE Edwin M. Mohler, M.D. (Degree or title)				23b. ADDRESS Smith, Mo.		23c. DATE SIGNED AUG 22 53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Aug 25, 53		24c. NAME OF CEMETERY OR CREMATORY Lula		24d. LOCATION (City, town, or county) (State) Smith Mo	
DATE REC'D BY LOCAL REG. 9-9-53		REGISTRAR'S SIGNATURE Carl Fisherband 90-0		25. FUNERAL DIRECTOR'S SIGNATURE Heward Franklin Smith, Inc ADDRESS			

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

RECEIVED DUNKLIN COUNTY HEALTH
DEPARTMENT 9-10-53
COUNTY FILE NUMBER 923 - 21

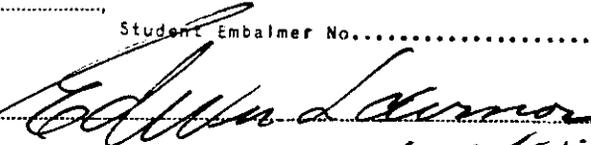
STATEMENT BY LICENSED EMBALMER

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.....



Signed.....
Student Embalmer

Licensed Embalmer No. 4840

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.