

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

5922

FILED MAR 7 1957

Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 62

Health, Welfare
Public
Service

300
1-56

All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY St. Francois		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Bonne Terre		a. STATE Missouri		b. COUNTY St. Francois	
		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Cantwell		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Bonne Terre Hosp.		Length of stay in 1b 3 days		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First William		Middle Franklin		Last Skaggs		Month Feb. Day 20 Year 1957	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 2nd. 1887	
				9. AGE (In years - last birthday) 70		IF UNDER 1 YEAR Months 0 Days 18 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mining			10b. KIND OF BUSINESS OR INDUSTRY Dolomite		11. BIRTHPLACE (City and state or country) Washington County, Mo.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME George Skaggs				14. MOTHER'S MAIDEN NAME Druella Jinkerson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 499 03 2719		17. INFORMANT Mrs. Altha Skaggs, Cantwell, Mo.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio sclerotic Heart Disease</u> DUE TO (b) <u>Generalized arterial sclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>Several years</u> <u>Several years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>2-18-57</u> , to <u>2-20-57</u> and last saw ^{him} <u>alive on 2/20/57</u> Death occurred at <u>1:45 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Paul Z. Jones MD</u> (Degree or title)				22b. ADDRESS <u>Flat River mo</u>		22c. DATE SIGNED <u>2/22/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Burial		2/23/1957		Workman Cemetery		St. Francois, Mo.	
24. FUNERAL DIRECTOR Boyer & Son ADDRESS Desloge, Mo				25. DATE RECD. BY LOCAL REG. Feb. 23, 1957		26. REGISTRAR'S SIGNATURE <u>Ether Reidloff</u>	

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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
Signature of Student Embalmer

Signed *J. T. Boyer*

Licensed Embalmer No. *36*

P. O. Address *Leestoye*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.