

FILED OCT 24 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

36330

State File No. 187

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 150 PRIMARY REG. DIST. NO. 5574 Registrar's No. 186

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Oregon</b> b. COUNTY <b>Unknown</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Rural VanBuren Twp.</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Klamath Falls</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>#50 Highway near Cockrell</b>		d. STREET ADDRESS (If rural, give location) <b>4623 Cannon Street.</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Thomas</b> b. (Middle) <b>Ray</b> c. (Last) <b>Skiena</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>10-11-57</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Jan 23 1899</b>	9. AGE (In years last birthday) <b>58</b>	IF UNDER 1 YEAR Months Days	IF UNDER 6 WKS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electr</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Rail Road</b>	11. BIRTHPLACE (State or foreign country) <b>Sayre Okla.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Wm Thomas Skiena</b>	13b. MOTHER'S MAIDEN NAME <b>Mary Weatherspoon</b>	14. NAME OF HUSBAND OR WIFE <b>Cecile Skiena</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Cecile Skeins</b> ADDRESS <b>Klamath Falls Ore.</b>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Stroke - Hemorrhage resulting from existing injuries of all kinds.</b> ANTECEDENT CAUSES <b>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</b> DUE TO (b) <b>Fractured Hip, Pastured Leg</b> DUE TO (c) <b>Pastured &amp; Bleed</b>		
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? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>accident</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Highway</b>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>Jackson Ore</b>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>10-11-57 12:50 p.m.</b>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR <b>from car collision</b>
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22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>W. C. Skiena, M.D., Deputy Coroner</b>	23b. ADDRESS <b>602 Park St. S.W.</b>	23c. DATE SIGNED <b>10-11-57</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>10/12/57</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Klamath Falls</b>	24d. LOCATION (City, town, or county) (State) <b>Klamath Falls Oregon</b>
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DATE REC'D BY LOCAL REG. <b>10-12-1957</b>	REGISTRAR'S SIGNATURE <b>N. B. Longford</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Langsford Funeral Home Lee's</b> ADDRESS <b>Summit Mo.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

4830

OCT 2 3 1957

OCT 23 1957

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

*N. B. Langford*

Licensed Embalmer No. *4962*

P. O. Address *Lee's Summit 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.