

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-000472

STATE FILE NUMBER

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 19

JAN 26 1959

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Butler</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Harvielli</u> <u>6120</u>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital No. 1</u>	Length of stay in lb <u>22 yrs.</u>	d. STREET ADDRESS (If outside, give location) <u>Route 1</u>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Skinner</u> Last <u>Skinner</u>	4. DATE OF DEATH Month <u>Jan.</u> Day <u>19,</u> Year <u>1959</u>
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5. SEX <u>Male</u> <u>2</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>D.K. Approx</u>	9. AGE (In years last birthday) <u>52</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>20</u>	IF UNDER 24 HRS. Hours <u>1</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer and Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>	11. BIRTHPLACE (City and state or country) <u>Unknown 9</u>	12. CITIZEN OF WHAT COUNTRY? <u>American</u>
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13a. FATHER'S NAME <u>Toney Denwoody</u>	13b. MOTHER'S MAIDEN NAME <u>Patty Denwoody</u>	14. NAME OF HUSBAND OR WIFE <u>Matilda Skinner</u>
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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) <u>Unknown</u>	16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT <u>St. Hospital No. 1, Fulton, Missouri</u>	Address
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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>Malignancy of Liver</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.) <u>1561</u>
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20e. CITY, TOWN, OR LOCATION	COUNTY	STATE
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20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK AT WORK	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from <u>June 15, 1937</u> to <u>Jan. 19, 1959</u> and <u>1920</u> on <u>St. Hospital No. 1</u> Death occurred at <u>1920</u> A. m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>MD</u>	22b. ADDRESS <u>State Hospital No. 1</u>	22c. DATE SIGNED <u>1/19/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>1/19-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>anatomical board</u>	23d. LOCATION (City, town, or county) (State) <u>Columbia and</u>
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24. FUNERAL DIRECTOR <u>J. O. Roberts</u> ADDRESS <u>Columbia and</u>	25. DATE RECD. BY LOCAL REG. <u>Jan. 19-1959</u>	26. REGISTRAR'S SIGNATURE <u>Maretha Lawrence</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

300 2  
1-57

All diseases in Part I must be causally related.

**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 .....

Licensed Embalmer No.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.**