

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-013551

STATE FILE NUMBER
1572

FILED APR 20 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

300
-57

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY PLATTE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		c. CITY OR TOWN PLATTE CITY	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION RESEARCH HOSP.		d. STREET ADDRESS (If outside, give location)	
Length of stay in lb 2 WKS.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED First Middle Last CHRIS A. SKILLMAN			4. DATE OF DEATH Month Day Year MAR. 19, 1959		
5. SEX M	6. COLOR OR RACE WH.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 21, 1881	9. AGE (In years last birthday) 77	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) BANKER		10b. KIND OF BUSINESS OR INDUSTRY BANKING	11. BIRTHPLACE (City and state or country) MISSOURI	12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME JOHN I. SKILLMAN	13b. MOTHER'S MAIDEN NAME SALLY THOMASON	14. NAME OF HUSBAND OR WIFE BEULAH SKILLMAN
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or if unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. 495-20-9957	17. INFORMANT Address BEULAH SKILLMAN, PLATTE CITY, 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) Metastatic Cancer Etio. Unknown		INTERVAL BETWEEN ONSET AND DEATH
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). Pneumonia		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 <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 1954 to Mar 19 1959 and last saw him alive on Mar 19, 1959 Death occurred at 9:15 on on the date stated above; and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title) Dr. Rollins Mitchell M.D.	22b. ADDRESS 924 Prof. Bldg K-L-100	22c. DATE SIGNED 3/23/59
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 3-19-59	23c. NAME OF CEMETERY OR CREMATORY PLATTE CITY CEM.
23d. LOCATION (City, town, or county) PLATTE CITY, MO.		(State) -

24. FUNERAL DIRECTOR ADDRESS ROLLINS & MITCHELL, PLATTE CITY, MO.	25. DATE RECD. BY LOCAL REG. 3-26-59	26. REGISTRAR'S SIGNATURE neva mitchell
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
Don A. Black

All diseases in Part I must be causally related.

MAY 29 1959

VS
MAY 19 1959
3-26-59

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 *Roland M. Giffey*

Licensed Embalmer No. *4725*
P. O. Address *Rolla City, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.