

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017080

STATE FILE NUMBER

FILED MAY 29 1959

Registration District No. 393 Primary Registration District No. 1002 Registrar's No. 2289

Health, Welfare, Public Service
300
-57
All diseases in Part I must be causally related.
Doctor, coroner, etc. must use only standard nomenclature.
John W. Walker
MEDICAL CERTIFICATION
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Carroll</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City North</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Carrollton</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>4506 N. Campbell</u> Length of stay in <u>6 wks</u>		d. STREET ADDRESS (If outside, give location) <u>310 W. First</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ABE</u> Middle <u>SKEITH</u> Last <u>SKEITH</u>		4. DATE OF DEATH Month <u>May</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>July 21 1890</u>
9. AGE (In years last birthday) <u>68</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>Retired Oil Salesman</u>	11. BIRTHPLACE (City and state or country) <u>Kansas U.S.A.</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>Oil</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	
14. NAME OF HUSBAND OR WIFE <u>Mabelle Skeith</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>495-07-3975</u>		17. INFORMANT <u>Mrs. Abe Skeith</u> Address <u>Carrollton Mo.</u>	
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>Quiescent cell carcinoma of the left lung</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Left lung</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>
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.) <u>163x</u>		20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>4/7/59</u> to <u>5/7/59</u> and last saw him alive on <u>5/6/59</u> . Death occurred at <u>6:50 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>John W. Walker</u> (Degree or title) <u>MD</u>		22b. ADDRESS <u>Kansas City, Mo.</u>	
22c. DATE SIGNED <u>5/7/59</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	
23b. DATE <u>May 7, 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Carroll Memory Gardens</u>	
23d. LOCATION (City, town, or county) <u>Carrollton</u>		(State) <u>Mo.</u>	
24. FUNERAL DIRECTOR <u>Standley & Libron</u> ADDRESS <u>Carrollton Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>5-7-59</u>	
26. REGISTRAR'S SIGNATURE <u>neva minshall</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 *Ben W. Gibson*

Licensed Embalmer No. *2961*
P. O. Address *Carrollton, Va*

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.