

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-020736

STATE FILE NUMBER

FILED JUL 9 1959 Registration District No. 73 Primary Registration District No. 4132 Registrar's No. 83

S. 300
ev. 1-57

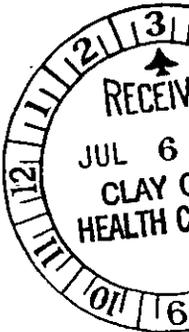
1. PLACE OF DEATH a. COUNTY Clay			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE California COUNTY San Bernardino		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Holt		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN San Bernadino		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ---		Length of stay in lb 1 day	d. STREET ADDRESS (If outside, give location) 3495 Sepulveda Ave.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last Skolfield			4. DATE OF DEATH Month June Day 29 Year 1959		
5. SEX Female	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 Sept. 8, 1913		9. AGE (In years last birthday) 45
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and state or country) Holt, Missouri	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME John J. Hunter		13b. MOTHER'S MAIDEN NAME Lelia Keas	
14. NAME OF HUSBAND OR WIFE George Skolfield		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 486-10-85426	
17. INFORMANT Geo. Skolfield, San Bernadino, Cal.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) Coronary Atherosclerosis DUE TO (c) 4201 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Hypothyroidism, moderate 10 yrs.		INTERVAL BETWEEN ONSET AND DEATH 10 min 2-3 yrs.	
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.)	
20c. TIME OF INJURY Hour _____ 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 Holt, Missouri		20g. COUNTY Clay		20h. STATE Missouri	
21. I attended the deceased from June 29, 1959 to June 29, 1959 and last saw her alive on June 29, 1959 Death occurred at 4:30/PM on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE John P. Mabrey M.D.		22b. ADDRESS Plattsburg, Mo.		22c. DATE SIGNED 6-29-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-2-59		23c. NAME OF CEMETERY OR CREMATORY Antioch	
23d. LOCATION (City, town, or county) Holt, Missouri		23e. STATE Missouri		23f. COUNTY Clay	
24. FUNERAL DIRECTOR Fry Funeral Home, Kearney, Mo.		25. DATE RECD. BY LOCAL REG. 7-3-59		26. REGISTRAR'S SIGNATURE Mabel Graham	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

6921 6 706



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 *Lucretia Jarman*

Licensed Embalmer No. *4589*
P. O. Address *Excelsior Springs, 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.