

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-018028

FILED VS MAY 6 1960

Registration District No. 333

Primary Registration District No. 6111

Registrar's No. 109

STATE FILE NUMBER

DEED

1. PLACE OF DEATH a. COUNTY <u>Scott</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Scott</u>	
b. CITY (If outside corporate limits, give TOWNSHIP OR TOWN) <u>Commerce Twp.</u> Length of stay in lb <u>20 yrs.</u>		c. CITY OR TOWN <u>Carroll Commerce Twp</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>at home 5 1/2 Mi. S of ILNO</u> Side Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>5 1/2 Mi. S of Illinois.</u> Residence on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>ANDREW</u> Last <u>SKINNER</u>			4. DATE OF DEATH Month <u>April</u> Day <u>17</u> Year <u>1960</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>Feb 27, 1934</u>	9. AGE (last birthday) <u>76</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>20</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
--------------------	-------------------------------	---	--------------------------------------	----------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Williamson Co. Tenn.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
---	--	--	---

13a. FATHER'S NAME <u>John Skinner</u>	13b. MOTHER'S MAIDEN NAME <u>Christine Pate</u>	14. NAME OF HUSBAND OR WIFE <u>General Morgan</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>Don't know</u>	17. INFORMANT (Name and address) <u>Mrs. J. A. Skinner Rte 1 Illinois.</u>
--	---	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> DUE TO (b) <u>& acute congestive failure</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)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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 _____ a.m. _____ p.m. Month, Day, Year _____	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 COUNTY STATE
---	--	--	---

21. I attended the deceased from 6/2/56 to 4/17/60 and last saw her alive on 4/13/60
Death occurred at 7:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>J. H. Kenney M.D.</u>	22b. ADDRESS <u>Capogian, Leavenworth</u>	22c. DATE SIGNED <u>4/24/60</u>
---	---	---------------------------------

23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4-19-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oakdale Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Commerce Missouri</u>
--	--------------------------	--	--

24. FUNERAL DIRECTOR ADDRESS <u>BI SPLINGHOFF FUNERAL HOME</u>	25. DATE RECD. BY LOCAL REG. <u>4-26-60</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Ella Hunter</u>
--	---	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Oliver Ames

Licensed Embalmer No. 447

P. O. Address Illms

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.