

1 DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 19 1960

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9764

-60-040244
STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis				Length of stay in 1b		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Alexian Brothers Hospital				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1419 N 8th St.,	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle SKYBROCK Last				4. DATE OF DEATH Month October Day 5th Year 1960			
5. SEX male	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 4/8/92	9. AGE (last birthday) 68	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crane Operator		10b. KIND OF BUSINESS OR INDUSTRY (retired)		11. BIRTHPLACE (City and state or country) Wisconsin		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Pete Skybrock			13b. MOTHER'S MAIDEN NAME not known			14. NAME OF HUSBAND OR WIFE Margaret Skybrock	
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. 353-01-1279		17. INFORMANT Margaret Skybrock, 1419 N 8th St., Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Broncho-pneumonia						INTERVAL BETWEEN ONSET AND DEATH @ 1 WK	
DUE TO (b)							
DUE TO (c)						491 X	
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 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. 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 OCT 4-1960 to OCT-5-1960 and last saw ^{her} _{him} alive on OCT-4-1960 Death occurred at 8:00 AM on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE John W. Drake M.D. (Degree or title)				22b. ADDRESS 740 S. 4th St. Louis		22c. DATE SIGNED 10-6-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 10/8/60	23c. NAME OF CEMETERY OR CREMATORY Memorial Park		23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.			
24. FUNERAL DIRECTOR DIEDRICH FUNERAL HOME, 8319 Hallaferry				25. DATE RECD. BY LOCAL REG. OCT 7 1960		26. REGISTRAR'S SIGNATURE Loard Smith, M.D.	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

OK
Paul Drake
Signy 10/12/60

INFORMED

DATE

TIME

PLACE OF INTERMENT

NAME OF INTERMENT HOME

NAME OF DECEASED

AGE

SEX

DATE OF DEATH

CAUSE

ON

PLACE OF DEATH

BY

DATE OF BURIAL

BY

PLACE OF BURIAL

ON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Elton H. Pennington

Licensed Embalmer No. 428

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.