

# MISSOURI DIVISION OF HEALTH AND WELFARE

## STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

652-61-005530  
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. \_\_\_\_\_

AMENDED

FILED VS FEB 20 1961

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Length of stay in 1b <b>3 1/2 years</b>	c. CITY OR TOWN <b>KANSAS CITY</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VA HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>819 W. 40th</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>WILLIAM</b> Last <b>SKENE</b>			4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>6</b> Year <b>1961</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>6-23-71</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Accountant (Ret)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Public Accountant</b>	9. AGE (last birthday) <b>89</b> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours _____ Min. _____
13a. FATHER'S NAME <b>David William Skene</b>		13b. MOTHER'S MAIDEN NAME <b>Sarah Gathright</b>	11. BIRTHPLACE (City and state or country) <b>Louisville, Kentucky</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes SAW</b>		14. NAME OF HUSBAND OR WIFE <b>unk</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
17. INFORMANT <b>Margaret Sweariffgen (Daughter)</b>		16. SOCIAL SECURITY NO. <b>VA HOSPITAL RECORDS, K. C. MO.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO (b) <b>Occlusion of left circumflex artery</b> DUE TO (c) <b>Generalized atherosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Bronchopneumonia with lung abscess</b> 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			INTERVAL BETWEEN ONSET AND DEATH
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. <b>VA</b> attended the deceased from <b>12-3-60</b> to <b>2-6-61</b> Death occurred at <b>4:50 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>R. H. OWINGS, M.D.</b>		22b. ADDRESS <b>VA Hospital, K. C. Mo.</b>	22c. DATE SIGNED <b>2-7-61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Feb. 9, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT-Olivet Cemetery</b>	23d. LOCATION (City, town, or county) <b>Kansas City MO.</b>
24. FUNERAL DIRECTOR <b>Muehlebach</b>		25. DATE RECD. BY LOCAL REG. <b>2-7-61</b>	26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>

(Licensed Embalmer's Statement on Reverse Side)

**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 R. L. Nichols

Licensed Embalmer No. 4999

P. O. Address K. C. Gro

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.