

**MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-61-041526**

AMENDED

Registration District No. 159 Primary Registration District No. 4249 Registrar's No. 38

STATE FILE NUMBER

**FILED DEC 1 1961**

1. PLACE OF DEATH a. COUNTY <b>Jefferson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Hillsboro</b>		Length of stay in 1b		c. CITY OR TOWN <b>Lemay</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Cedar Grove Conv. Home</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>317 E. Holden</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>G.</b> Last <b>Skiles</b>			4. DATE OF DEATH Month <b>November</b> Day <b>16,</b> Year <b>1961</b>										
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>10/24/1893</b>		9. AGE (last birthday) <b>68</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>			11. BIRTHPLACE (City and state or country) <b>Van Buren, Missouri</b>			12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>				
13a. FATHER'S NAME <b>Jobe Skiles</b>				13b. MOTHER'S MAIDEN NAME <b>Ann Hanger</b>				14. NAME OF HUSBAND OR WIFE <b>Glenna Hoskins Skiles</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b> <b>None</b>						17. INFORMANT Address <b>Glenna Skiles 317 E. Holden Lemay, 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>Generalized Arteriosclerosis</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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 INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>													
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 <b>Aug. 20, 1961</b> to <b>Nov. 16, 1961</b> and last saw him alive on <b>Nov. 12, 1961</b> Death occurred at <b>5:20 P.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <b>Robert D. Sanders, M.D.</b>				22b. ADDRESS <b>1507 Case St. St. Louis</b>				22c. DATE SIGNED <b>11-18-61</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>Nov. 20, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Trinity Cemetery</b>			23d. LOCATION (City, town, or county) (State) <b>Lemay, Missouri</b>						
24. FUNERAL DIRECTOR ADDRESS <b>C. Hoffmeister Mortuaries</b> <b>7814 So. Broadway St. Louis, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>11/21/61</b>		26. REGISTRAR'S SIGNATURE <b>Delta Robinson, Dep.</b>							

DATE RECEIVED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

1961 1 31 SA

**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

*John S. Dennis*

Licensed Embalmer No. 4194

P. O. Address. St. Louis

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.