

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-047478

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 160 Primary Registration District No. 3029 Registrar's No. 179

FILED DEC 19 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>JEFFERSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>JEFFERSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CRYSTAL CITY</u>		c. CITY OR TOWN <u>CRYSTAL CITY</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>CRYSTAL CITY, MO.</u>		d. STREET ADDRESS (If outside, give location) <u>109 CHURCH PLACE</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nicholas</u> Middle <u>J</u> Last <u>Skiadas</u>		4. DATE OF DEATH Month <u>12</u> Day <u>8</u> Year <u>62</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-14-23</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GLASSWORKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>P.P.G.CO.</u>	11. BIRTHPLACE (City and state or country) <u>CRYSTAL CITY, MO.</u>
13a. FATHER'S NAME <u>JOHN SKIADAS</u>		13b. MOTHER'S MAIDEN NAME <u>FRANCES BAUER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WWII</u>		17. INFORMANT <u>MARY SKIADAS</u> Address <u>CRYSTAL CITY, MO.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ 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 checked="" 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 <u>Coverer's View</u> and last saw her alive on _____ Death occurred at <u>4:00 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>James C. Johnson M.D. Crow</u>		22b. ADDRESS <u>Fenton, Mo.</u>	22c. DATE SIGNED <u>12-8-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>12-11-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ROSELAWN MEMORIAL</u>	23d. LOCATION (City, town, or county) <u>CRYSTAL CITY, MO.</u> (State)
24. FUNERAL DIRECTOR <u>GENTRY R. POLITTE</u> ADDRESS <u>CRYSTAL CITY, MO.</u>		25. DATE RECD. BY LOCAL REG. <u>12-10-62</u>	26. REGISTRAR'S SIGNATURE <u>James G. [Signature]</u>

USE BLACK INK OR TYPEWRITER RIBBON

JAN 16 1963
JAN 22 1963

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 Robert R. Polite

Licensed Embalmer No. 3481
P. O. Address Crystal City, Md.

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.