

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-049660

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 3474 Primary Registration District No. 500 Registrar's No. 3817

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 16 1963

VS 300
Rev. 4/59

146.30

2 212

3

4 1

5 0

6

7 0

8 2

9 9000

10 21

11 400

12 86-2

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) e. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Moline		Length of stay in 1b 4 Mo.	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Hallsferry Memorial Home		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5330 Pershing Ave. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Jeannette Skillington			4. DATE OF DEATH Month Day Year 12-27-62
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2-8-81
9. AGE (last birthday) 81		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) Retired Telephone Sup.		10b. KIND OF BUSINESS OR INDUSTRY Telephone	11. BIRTHPLACE (City and state or country) Florissant, Mo.
12. CITIZEN OF WHAT COUNTRY U. S.		13a. FATHER'S NAME Miles Skillington	
13b. MOTHER'S MAIDEN NAME Alice Smith		14. NAME OF HUSBAND OR WIFE None	
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. None	17. INFORMANT Address Mrs. Anthony Foeller, Florissant, Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C Cachexia & Inanition			INTERVAL BETWEEN ONSET AND DEATH Weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Non-union of fracture of left hip			5 mos.
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Impacted fracture of left humerus. Fracture of left Calcaneus.			PART III. If deceased was female was there a pregnancy in last 90 days <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) Fell on steps at 11934 Gist Rd.	
20c. TIME OF INJURY X 1:30 p.m.	Month, Day, Year July 25, 1962		
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.) steps of residence	20f. CITY, TOWN, OR LOCATION 38	COUNTY STATE St. Louis Mo.
21. I attended the deceased from 7-25-62 to 12-27-62 and last saw her/him alive on 12-27-62 Death occurred at 9:45 AM CST on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Robert C. Beck, D.O.		22b. ADDRESS 1735 S. Florissant Rd. Florissant, Mo.	22c. DATE SIGNED 12-28-62
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12-29-62	23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery	23d. LOCATION (City, town, or county) (State) Florissant, Mo.
24. FUNERAL DIRECTOR ADDRESS White-Mullen Mortuary, Ferguson, Mo.		25. DATE RECD. BY LOCAL REG. 12-28-62	26. REGISTRAR'S SIGNATURE John C. Murphy, M.D.

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

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 *Paul J. Lehman*

Licensed Embalmer No. 3395

P. O. Address 281 mi 35 mo

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.