MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

0039753

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 88 Primary Registration District No. 5326 Registrar's No. 64 [illegible] STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

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Rev. 4/59

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF	DATE AMENDED	BY AFFIDAVIT OF
				DOCUMENT

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH
a. COUNTY CRAWFORD
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN MERAMEC
Length of stay in 1b: 5 MON.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION MUMMERT'S R. HOME
Inside Limits Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO. b. COUNTY CRAWFORD
c. CITY OR TOWN STEELVILLE, MO.
Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location)
Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First STEPHEN Middle EBERT Last SKAGGS

4. DATE OF DEATH Month 10 Day 19 Year 64

5. SEX

6. COLOR OR RACE

7. Married ☐ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH 5-13-86

9. AGE (last birthday) 78

IF UNDER 1 YEAR Months 5 Days 6
IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TIMBER-MAN

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country) DAVISVILLE, MO.

12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME JAMES SKAGGS

13b. MOTHER'S MAIDEN NAME ALICE WHITACRE

14. NAME OF HUSBAND OR WIFE MAUDE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CEREBRAL hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 28 hrs.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) BRONCHIAL PNEUMONIA — 12 hrs.

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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 8-10-64 to 10-19-64 and last saw ~~her~~ him alive on 10-19-64
Death occurred at 10:30 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) George W. Johnson D.O.

22b. ADDRESS STEELVILLE, MO.

22c. DATE SIGNED 10-20-64

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE 10-21-64

23c. NAME OF CEMETERY OR CREMATORY BONNE TERRE

23d. LOCATION (City, town, or county) (State) BONNE TERRE, MO.

24. FUNERAL DIRECTOR ADDRESS Thomas L. Halbert

25. DATE RECD. BY LOCAL REG. 10-21-64

26. REGISTRAR'S SIGNATURE Warren L. Beck

(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 Carl J. Glenn

Licensed Embalmer No. 4707

P. O. Address Rolla, 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.