

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-028019

FILED VS JUL 27 1960

Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 289

STATE FILE NUMBER

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>St. Francois</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>St. Francois</b> |  |
| b. CITY (if outside corporate limits, give TOWNSHIP only)<br><b>Bonne Terre</b>                            |  | Length of stay in 1b<br><b>3 Weeks</b>  | c. CITY OR TOWN <b>Flat River</b><br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                    |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Bonne Terre Hospital</b> |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (if outside, give location)<br><b>104 Bennett</b><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|---|----------------------------------|---|--|---|--|---|
| 3. NAME OF DECEASED (Type or print)<br>First <b>Thornton</b> Middle <b>Willburn</b> Last <b>Skaggs</b>                |                                  |   | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>17</b> Year <b>1960</b> |   |  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><b>June 16, 1885 - 75</b>                        | 9. AGE (last birthday)<br><b>75</b>                                       | IF UNDER 1 YEAR IF UNDER 24 HR<br>Months Days Hours Min. |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Ret. Miner</b>      |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Lead Company</b>  |  | 11. BIRTHPLACE (City and state or country)<br><b>Washington, Co., Mo.</b> |  | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b> |
| 13a. FATHER'S NAME<br><b>Henry Skaggs</b>   |                                  | 13b. MOTHER'S MAIDEN NAME<br><b>Brickley</b>  |  | 14. NAME OF HUSBAND OR WIFE<br><b>Divorced</b>                            |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b> |                                  | 16. SOCIAL SECURITY NO.<br><b>488 16 5895</b>   |  | 17. INFORMANT Address<br><b>Willard Skaggs, Flat River, Mo</b>            |  |   |

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 weeks</b> |
| DUE TO (b) <b>Generalized arteriosclerosis</b>   |  |  |
| DUE TO (c)   |  |  |

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| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> N- <input type="checkbox"/> Unknown |  |
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| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour <b>7:40</b> a.m. p.m.   | Month, Day, Year <b>6-19-60</b>   |  |  |

|  |  |                              |        |       |
|--|--|------------------------------|--------|-------|
| 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 6-19-60 to 7-17-60 and last saw him live on 7-17-60  
Death occurred at 7:40 P on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title)<br><b>W. Stantoni MD.</b> | 22b. ADDRESS<br><b>Flat River, Mo.</b> | 22c. DATE SIGNED<br><b>7/18/60</b> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 23b. DATE<br><b>7/20/1960</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Francois Mem. Pk</b> | 23d. LOCATION (City, town, or county) (State)<br><b>St. Francois Co., Missouri</b> |
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|   |                               |  |  |
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| 24. FUNERAL DIRECTOR<br><b>C.Z. Boyer &amp; Son</b> | ADDRESS<br><b>Desloge, Mo</b> | 25. DATE RECD. BY LOCAL REG.<br><b>July 19, 1960</b> | 26. REGISTRAR'S SIGNATURE<br><b>Eather Rudloff</b> |
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed E. Z. Bagger

Licensed Embalmer No. 1671

P. O. Address Heston

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.