

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **12352**

63-049963
STATE FILE NUMBER

FILED JAN 9 1964

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Lincoln	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis		Length of stay in 1b	c. CITY OR TOWN Foley Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri Baptist Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) RFD - Kings Lake District Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Granville Otis Skaggs			4. DATE OF DEATH Month Day Year December 12, 1963
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/26/1904
9. AGE (last birthday) 59		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) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Trucking Co.	11. BIRTHPLACE (City and state or country) Cherryville, Mo.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Stephen Skaggs	
13b. MOTHER'S MAIDEN NAME Maude Conway		14. NAME OF HUSBAND OR WIFE Artie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No. Nil.		16. SOCIAL SECURITY NO. 498-12-1430	17. INFORMANT Artie Skaggs, Foley, Mo. Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE Pulmonary Embolism; Contib: Bilateral Fractures of Os Calcis: Suffered in fall from ladder while working on trailer in vicinity of 6810 Perscott Street 1-15 P.M. on November 22nd 1963.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) accident 901.3 87			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 SUICIDE HOMICIDE A <input type="checkbox"/> <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) See above	
20c. TIME OF INJURY Hour s.m. p.m. 2:15 11-22-63	20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.) Factory platform 08	20f. CITY, TOWN, OR LOCATION COUNTY STATE at Sours, Mo
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____. Death occurred at 5:20 A m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Helen L Taylor, Coroner		22b. ADDRESS 1300 Clark Ave.	22c. DATE SIGNED 12-13-63 (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12-15-63	23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	23d. LOCATION (City, town, or county) (State) Clarksville, Mo.
24. FUNERAL DIRECTOR ADDRESS Ricks Funeral Home, Elsberry, Mo.		25. DATE RECD. BY LOCAL REG. DEC 13 1963	26. REGISTRAR'S SIGNATURE Joan Smith, M.D.

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

DATE AMENDED

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USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

100-10-200

100-10-200

100-10-200

JAN 9 1984

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 J. Barnes

Licensed Embalmer No. 4108

P. O. Address St Louis 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.