

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REC'D MAY 10 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

13896
Do not use this space.

1. PLACE OF DEATH
 (a) County Jackson Registration District No. 395
 (b) Township R E MO Primary Registration District No. 1002 Registrar No. 1650
 (c) City R E MO (d) Street No. 19 E San Hosp St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
600
 2. PRINT FULL NAME Jennie Sknick
 (a) Residence, No. 907 Cherry St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Unknown
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb - 17 - 1859
 7. AGE YEARS 80 MONTHS 2 DAYS 10 If LESS than 1 day, _____ hrs. or _____ min.
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. none
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MO
 13. NAME Mike Sknick
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MO
 15. MAIDEN NAME Sknick
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MO
 17. INFORMANT (ADDRESS) Resed Clark
 18. BURIAL, CREMATION, OR REBURYAL PLACE MO DATE 31-19-39
 19. FUNERAL DIRECTOR (ADDRESS) 536 Campbell
 20. FILED Apr 19 1939 M. M. Brown Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-17-39
 22. I HEREBY CERTIFY, That I attended deceased from 4-14-39, 19____, to 4-17-39, 19____
 I last saw alive on 4-17-39, 19____. Death is said to have occurred on the date stated above, at _____ m.
 The principal cause of death and related causes of importance were as follows:
Miliary Tuberculosis Date of onset _____
lewis
75-
 Other contributory causes of importance:
Tuberculosis of cranium
Enteritis
 Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? Yes
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
 Manner of injury _____
 Nature of injury _____
 24. Was disease or injury in any way related to occupation of deceased?
 If so, specify _____
 (Signed) P. J. De Mann M. D.
Dr. J. C. Brown

STATE OF ALABAMA
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

DATE OF DEATH
PLACE HERE
PLACE HERE
PLACE HERE
PLACE HERE
PLACE HERE

PLACE HERE

PLACE HERE

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 _____

Registered Apprentice No. _____, working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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 this body is not embalmed, above space should be left blank.