

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 30890
3453

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. _____

1. PLACE OF DEATH: 10231
(a) County Jackson
(b) City or town Kansas city
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: mercy
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 wks (Specify whether ✓)
In this community _____ years, months or days

3. (a) PRINT FULL NAME Phyllis Carroll Skinner
3. (b) If veteran, Phyllis Carroll Skinner name war _____ No. _____

4. Sex female 5. Color or race white
6. (a) Single, widowed, married, divorced ✓
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Mar-22-1940 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
				hr. min.
		<u>5</u>	<u>9</u>	

9. Birthplace marshall, Mo. (City, town, or county) (State or foreign country)

10. Usual occupation baby

11. Industry or business _____

MOTHER FATHER
12. Name Orville Skinner
13. Birthplace Stone Co, Mo. (City, town, or county) (State or foreign country)
14. Maiden name Phyllis Skinner
15. Birthplace Saline Co, Mo. (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mar. L. S. Skinner

(b) Address Stater, Mo.

17. (a) burial (b) Date of removal 9-2-40 (Month) (Day) (Year)

(c) Place: burial Stater, Mo.

18. (a) Signature of funeral director Hall Brothers

(b) Address Stater Mo.

19. (a) Sept. 3, 1940 (Date received local registrar) (b) M. M. Crane (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Saline
(c) City or town Stater (If outside city or town limits, write "RURAL")
(d) Street No. 0 (If rural, give location) ✓
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 1
year 1940 hour 8 minute 35 A.M.
21. I hereby certify that I attended the deceased from Sept 1
1940, to Sept 1, 1940
that I last saw him alive on Sept 1, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Bilateral bronchopneumonia
Broncho-pneumonia

Due to _____ Duration _____
Due to 29

Other conditions Masses
(include pregnancy within 3 months of death)

Major findings: _____ PHYSICIAN _____
Of operations Broncho-pneumonia
with abscess
Of autopsy the bases of lungs were
2 TB foci on R. apex
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature W. B. Federber (M. D. or other) _____
Address 1316 Park Bldg Date signed Sept 1940

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.....

A. C. Hill, Registered Apprentice No.
working under my personal supervision.

Signed.....

A. C. Hill
Licensed Embalmer No. 5090

P. O. Address Staten, 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 this body is not embalmed, above space should be left blank.