

DEPARTMENT OF COMMERCE ¹⁹⁴⁴ STATE BOARD OF HEALTH
BUREAU OF THE CENSUS STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 689

Primary Registration District No. 3033

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Pike

(b) City or town Louisiana
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Pike County Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 min.
(Specify whether)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Pike

(c) City or town _____
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Janice Ann Skirvin

8. (b) If veteran, name war _____ 8. (c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 7
year 1941 hour 4 P.M. minute 36 P.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

4. Sex female 5. Color or race white

6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased April 7 1941
(Month) (Day) (Year)

that I last saw h_____ alive on _____, 19____; and that death occurred on the date and hour stated above.

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. 5 min.

Immediate cause of death Premature Labor

Due to _____

9. Birthplace Louisiana Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business none

Due to 159

Other conditions (Include pregnancy within 3 months of death) _____

MOTHER FATHER

12. Name William Harold Skirvin

13. Birthplace Calhoun Co. Illinois
(City, town, or county) (State or foreign country)

14. Maiden name Ellen Alberta Penterbaugh

15. Birthplace Calhoun Co. Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Hospital records

(b) Address Louisiana, Mo

17. (a) Burial (b) Date thereof 4/8/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Clarksville Mo

18. (a) Signature of funeral director none

(b) Address Clarksville Mo

19. (a) 4-7-41 (b) J. H. Hays
(Date received local registrar) (Registrar's signature)

Major findings: Of operations _____

Of autopsy _____

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? 20

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

23. Signature C. H. B. ... (M. D. or other) 4/7/41

Address Clarksville Mo Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Rev. 5-17-39 I X1031

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.

RECEIVED

District Health Officer No. 10

District File Number 5-41-1019

Date Filed MAY 20 1941

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.