

Registration District No. 748

Primary Registration District No. 5983

Registrar's No.

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

1. PLACE OF DEATH:

(a) County. WAYNE REYNOLDS  
(b) City or town. RIVERSIDE Mo. Webb  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1 Turp  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State. Missouri (b) County. Reynolds  
(c) City or town. Riverside Webb  
(If outside city or town limits, write "RURAL") Turp  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME WILLIAM HARRISON SKAGGS

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 18th year 1942 hour 7:00 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from April 15 1942 to April 15 1942 that I last saw him alive on 4/15/42 and that death occurred on the date and hour stated above.

4. Sex. MALE 5. Color or race White 6. (a) Single, widowed, married, divorced. MARRIED  
6. (b) Name of husband or wife ELLA M. SKAGGS 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased MARCH 22 1872  
(Month) (Day) (Year)

Immediate cause of death. apoplexy Duration \_\_\_\_\_  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

8. AGE: Years 70 Months 0 Days 26 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation HOUSE WORK

11. Industry or business Farming

12. Name HOBBS SKAGGS  
13. Birthplace CRAWFORD CO Mo  
(City, town, or county) (State or foreign country)  
14. Maiden name JULIA Odell  
15. Birthplace REYNOLDS Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant ELLA M SKAGGS  
(b) Address RIVERSIDE Mo

17. (a) BURIAL (b) Date thereof APR 20 1942  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation DES ARC Mo.

18. (a) Signature of funeral director M. W. Gish  
(b) Address Piedmont Mo

19. (a) May 4-42 (b) Essie Evans  
(Date received local registrar) (Registrar's signature)

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
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. H. Cline M.D. (M. D. or other)  
Address Piedmont, Mo Date signed \_\_\_\_\_

RECEIVED

District Health Officer No. *R*

District File Number *842687*

Date Filed \_\_\_\_\_

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 *me*

\_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed *Norman W. Gish*

Licensed Embalmer No. *3387*

P. O. Address *Edmond 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, fact should be so stated above.**