

No. 2
5-43
17-39
X36671

FILED DEC 10 1945

Registration District No. 275

Primary Registration District No. 5942

Registrar's No. 126

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

1. PLACE OF DEATH:

(a) County... Phelps
(b) City or town... Rolla - Rural - Rolla township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 90 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Louisiana (b) County... ? 999
(c) City or town... Shreveport 16
(If outside city or town limits, write "RURAL")
(d) Street No... 1616 Pierre Ave. 0
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No) 2
If yes, name country _____

3. (a) PRINT FULL NAME William Skyles

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced 4
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Dec. 7 1886
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
59 10 20 hr. min.

9. Birthplace Rolla, Phelps Co., Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Gunsmith

11. Industry or business _____

12. Name Andy Jackson Skyles
13. Birthplace Rolla, Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Rebecca Ann Mellon
15. Birthplace Arkansas
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. H. T. Dungan

(b) Address Shreveport, La.

17. (a) Removal (b) Date thereof 10-30-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Shreveport La.

18. (a) Signature of funeral director Null & Son Funeral Home
(b) Address 508 West 8th St., Rolla Mo.

19. (a) Oct. 29, 1945 (b) Mr. Juanita Harvey
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 27
year 1945 hour 11 minute 45 P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him indeed October 27, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Skull Fracture
Internal injuries, Compound
fracture right leg. Deep
Laceration left side.
Struck by Truck while walking on
Due to highway... intoxication.

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

Major findings: _____
Of operations _____
Of autopsy 70°

Duration
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) Accident 81

(b) Date of occurrence Oct. 27, 1945

(c) Where did injury occur? St. James Phelps Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Highway 66 West edge of City

(e) Means of injury see above
While at work 10

23. Signature S. L. Null - Coroner
Address 508 West 8th St., Rolla Date signed 10/29/45

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..... *S. L. Nunez*

Licensed Embalmer No. *2297*

P. O. Address..... *Rolla 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Dec
Registrar's No. 126

Registration District No. 275 Primary Registration District No. 5942

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

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME William Skyles
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

20. DATE OF DEATH: Month Dec Day 7 Year 1945 Hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____ and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife Vellie Skyles 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased July 7 (Month) (Day) (Year)

Duration _____
Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____

8. AGE: Years 58 Months 23 Days 23 If less than one day _____ hr. _____ min.
9. Birthplace _____ (City, town, or county) (State or foreign country) mo

10. Usual occupation _____
11. Industry or business _____
12. Name _____
13. Birthplace (City, town, or county) (State or foreign country) _____
14. Maiden name _____
15. Birthplace (City, town, or county) (State or foreign country) _____

16. (a) Informant _____ (b) Address _____
17. (a) (Burial, cremation, or removal) _____ (b) Date thereof (Month) (Day) (Year) _____
(c) Place: burial or cremation _____
18. (a) Signature of funeral director _____ (b) Address _____

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 _____ (M. D. or other) _____
Address _____ Date signed _____

19. (a) Jan 14, 1946 (Date received local registrar) (b) Mrs. Juanita Harvey (Registrar's signature)

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

SUPPLEMENTARY

38207