

State File No. _____
Registrar's No. 5

Registration District No. 42 Primary Registration District No. 1000

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution State Hosp # 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 18 yrs 9 mos 20 days
(Specify whether years, months or days)
In this community 18 yrs 9 mos 20 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Carroll
(c) City or town Carrollton
(If outside city or town limits, write "RURAL")
(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 Berx Augustus Sknesz
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, single
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: May 24 1878
(Month) (Day) (Year)

8. AGE: Years 68 Months 7 Days 10
If less than one day _____ hr. _____ min.

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

10. Usual occupation Student

11. Industry or business _____

MOTHER FATHER

12. Name George J Sknesz

13. Birthplace Germany

14. Maiden name Therese Billa

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant Ma Mrs Sknesz

(b) Address Miami Sta, Mo

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 1-4-47
(Month) (Day) (Year)

(c) Place: burial or cremation Carrollton Mo

18. (a) Signature of funeral director Stanley and Wilton Carrollton Mo

(b) Address _____

19. (a) 1-7-46 (Date received local registrar) (b) to b Jenkins (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month January day 4 year 1947 hour 11:20 minute _____ M.
21. I hereby certify that I attended the deceased from Jan 3 1947 to Jan 4 1947 that I last saw him alive on Jan 4 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis Duration 4 yr

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

Major findings: Of operations 93 D
Of autopsy _____

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 L J Shuck (M. D. or other)
Address State Hosp # 2 Date signed 1/4/47

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

Suess

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..... Ben W. Gibson

Licensed Embalmer No. 2961

P. O. Address Carrollton, 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.