9870

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAR 21 1947

Registration District No. 4-92-14

Primary Registration District No. 9-6-5-2-R 4 2 2 2

Registrar's No. 34

1. PLACE OF DEATH:

(a) County: LINCOLN

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

(c) Name of hospital or institution: family residence (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)

In this community all of life

2. USUAL RESIDENCE OF DECEASED:

(a) State: MISSOURI (b) County: LINCOLN

(c) City or town: Winfield (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.? _____ years.

3. (a) PRINT FULL NAME: JAMES DEE SKINNER

3. (b) If veteran, name war: NO

3. (c) Social Security No.: NO

4. Sex: Male

5. Color or race: W

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

6. (b) Name of husband or wife: Lilly MAY ELSTON

6. (c) Age of husband or wife if alive: — years

7. Birth date of deceased: July (Month) 9 (Day) 1873 (Year)

8. AGE: Years 73 Months 7 Days 22 If less than one day _____ hr. _____ min.

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

10. Usual occupation: FARMING

11. Industry or business: _____

FATHER 12. Name: James Skinner

FATHER 13. Birthplace: Mich (City, town, or county) (State or foreign country)

MOTHER 14. Maiden name: Mary Eliz. DUEY

MOTHER 15. Birthplace: Mich (City, town, or county) (State or foreign country)

16. (a) Informant's own signature: Floyd J. Skinner

(b) Address: Winfield, Mo.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: 3-3-47 (Month) (Day) (Year)

(c) Place: burial Winfield, Mo.

18. (a) Signature of funeral director: Charles Rich

(b) Address: Winfield, Mo.

19. (a) 3/4/47 (Date received by registrar) (b) J. E. Vennik (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 28 year 1947 hour 4 minute 00 P.M.

21. I hereby certify that I attended the deceased from 1-12-1946, to 2-28-1947, that I last saw him alive on 2-27-1947, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: myocarditis (chronic)	
Due to: Arterial Sclerosis	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

Major findings: Of operations: 9 1

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? (Specify type of place)

While at work? — (e) Means of injury: —

23. Signature: J. E. Vennik (M. D. or other)

Address: Old Monroe, Mo Date signed: 3/4/47

(Licensed Embalmer's Statement on Reverse Side)

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

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.

Form 5-17-39 Rev. 5-17-39 I X19511

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. 4012

P. O. Address Winfield, 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.

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. April

Registration District No. 180 Primary Registration District No. 4292 Registrar's No. 34

1. PLACE OF DEATH:
(a) County Lincoln
(b) City or town Winfield
(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 years, months or days)
In this community

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 James D. Skinner
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 Wid
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive
7. Birth date of deceased JULY (Month) 4 (Day) 1873 (Year)
8. AGE: Years 73 Months Days If less than one day hr. min.
9. Birthplace WINFIELD (City, town, or county) MO. (State or foreign country)
10. Usual occupation
11. Industry or business
12. Name JAMES SKINNER (Father)
13. Birthplace UNKNOWN (City, town, or county) (State or foreign country)
14. Maiden name MARY ELIZABETH DUEY (Mother)
15. Birthplace UNKNOWN (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
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 28 year 1944 hour minute M.
21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw him alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
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? (Specify type of place)
While at work? (e) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

9870