

No. 2
12-45
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 25 1947
Registration District No. 128

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
Primary Registration District No. 5465

State File No. 27468
Registrar's No. 693

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Rural Springfield N. Campbell Sup.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Greene County Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community 4 Months 29 days (Specify whether years, months or days)

3. (a) PRINT FULL NAME Pearl Louise Skaggs,
3. (b) If veteran, name war None 3. (c) Social Security No. None

FEMALE / **White** (a) Single, widowed, married, divorced Single
4. ~~Male~~ / White race _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased March 3, 1947
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>0</u>	<u>4</u>	<u>29</u>	hr. _____ min. _____

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

10. Usual occupation Infant

11. Industry or business At Home

MOTHER FATHER { 12. Name Stanley A. Skaggs
13. Birthplace Clever Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Lillie Tool
15. Birthplace Manchester Okla.
(City, town, or county) (State or foreign country)

16. (a) Informant Lillie Skaggs,
(b) Address R. # 11 Springfield Mo.

17. (a) Burial (b) Date thereof 8-5-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Clever Mo. Cem.

18. (a) Signature of funeral director W. Klingner & Co.
(b) Address Springfield Mo.

19. (a) 8-4-47 (b) W. E. Handley MD
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Greene 39
(c) City or town Springfield - Rural 0
(If outside city or town limits, write "RURAL")
(d) Street No. R # 11, Box 964 0
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 2
year 1947 hour 8 minute 45 P. M.

21. I hereby certify that I attended the deceased from March 7, 1947 to Aug 2, 1947, that I last saw her alive on Aug 2, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death: Spina Bifida Hydrocephalus, acquired
Due to _____
Due to _____

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

Major findings: _____
Of operations _____
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 James R. Anso (M. D. or other) 0
Address Springfield Mo. Date signed 8-4-47

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, fact should be so stated above.