

FILED AUG 2 - 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

24386

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **5972**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b>		b. COUNTY	
b. CITY OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. LENGTH OF STAY (in this place) <b>3 1/2 months</b>		STREET ADDRESS (If rural, give location) <b>3509 Park Avenue</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Incarinate Word Hospital</b>					

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) <b>Elizabeth</b>	b. (Middle) <b>Bernice</b>	c. (Last) <b>Skipworth</b>	(Month) <b>July</b>	(Day) <b>10</b>	(Year) <b>1955</b>

5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>June 8, 1907</b>	9. AGE (In years last birthday) <b>48</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Registered Nurse</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Fred Lohse</b>	13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Mr. James W. Skipworth</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>490-05-1717</b>	17. INFORMANT'S SIGNATURE OR NAME <b>James W. Skipworth</b>	ADDRESS <b>3509 Park Avenue</b>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Catheter</b>		<b>6 wks</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Metastatic carcinoma</b> DUE TO (c) <b>Carcinoma of stomach</b>		<b>6 mo</b> <b>13 mo</b>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>151X</b>
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22. I hereby certify that I attended the deceased from **1946** **7-10**, 19**55**, that I last saw the deceased alive on **7-10**, 19**55**, and that death occurred at **5:05 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>J. S. Michael</b>	(Degree or title) <b>SM D.O.</b>	23b. ADDRESS <b>872 Olive</b>	23c. DATE SIGNED <b>7-11-55</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>July 13, 1955</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Friedens Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis Missouri</b>
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DATE REC'D BY LOCAL REG. <b>Jul 11 1955</b>	REGISTRAR'S SIGNATURE <b>J. Carl Smith MD</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Math Hermann &amp; Son Inc.</b>	ADDRESS <b>2161 E. Fair Ave</b>
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

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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 ....., Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 37

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.