

S. No. 300  
V. 10.48

FILED OCT 8 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **32795**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **500** Registrar's No. **2153**

1. PLACE OF DEATH  
a. COUNTY **St. Louis County**

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
a. STATE **Missouri** b. COUNTY \_\_\_\_\_

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN **Koch, Missouri**

c. CITY OR TOWN **3 St. Louis**

d. Is Residence within limits of a city or incorporated town? Yes  No

d. FULL NAME OF HOSPITAL OR INSTITUTION **Robert Koch Hospital**

e. STREET ADDRESS (If rural, give location) **St. Louis Chronic Hosp. 5800 Arsenal**

3. NAME OF DECEASED (Type or Print)  
a. (First) **Orlando** b. (Middle) \_\_\_\_\_ c. (Last) **Skinner**

4. DATE OF DEATH (Month) (Day) (Year) **Sept. 11, 1956**

5. SEX **Male**

6. COLOR OR RACE **White**

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **never married**

8. DATE OF BIRTH **5-24-74**

9. AGE (In years last birthday) **82** IF UNDER 1 YEAR Months \_\_\_\_\_ Days \_\_\_\_\_ IF UNDER 24 HRS. Hours \_\_\_\_\_ Min. \_\_\_\_\_

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **none**

10b. KIND OF BUSINESS OR INDUSTRY **none**

11. BIRTHPLACE (City and State or Foreign Country) **Rochester, New York**

12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13a. FATHER'S NAME **Henry Skinner**

13b. MOTHER'S MAIDEN NAME **Martha Clemons**

14. NAME OF HUSBAND OR WIFE **none**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) **no**

16. SOCIAL SECURITY NO. **none**

17. INFORMANT'S SIGNATURE OR NAME ADDRESS **Robert Koch Hospital, Koch, Missouri**

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, asphyxia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION  
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) **Pulmonary Tuberculosis**  
ANTECEDENT CAUSES  
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  
DUE TO (b) \_\_\_\_\_  
DUE TO (c) \_\_\_\_\_  
II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death. **Diabetes mellitus**

INTERVAL BETWEEN ONSET AND DEATH **28 mo.**  
**12 yrs.**

19a. DATE OF OPERATION **none**

19b. MAJOR FINDINGS OF OPERATION **none**

20. AUTOPSY? YES  NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify) **none**

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) **none**

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) **002X**

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) **none**

21e. INJURY OCCURRED WHILE AT WORK  NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? \_\_\_\_\_

22. I hereby certify that I attended the deceased from **7-2, 1954**, to **9-11, 1956**, that I last saw the deceased alive on **9-11, 1956**, and that death occurred at **12:35 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) **Axel R. Cronan, M.D.**

23b. ADDRESS **Robert Koch Hospital**

23c. DATE SIGNED **9-11-56**

24a. BURIAL, CREMATION, REMOVAL (Specify) **BURIAL**

24b. DATE **9-12-1956**

24c. NAME OF CEMETERY OR PLACE OF INTERMENT **ST. TRINITY LUTHERAN**

24d. LOCATION (City, town, or county) (State) **ST. LOUIS CO. MISSOURI**

DATE REC'D BY LOCAL REG. **9-12-56** REGISTRAR'S SIGNATURE **Herbert R. Donahue**

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS **McLAUGHLIN F.H., INC. 2301 LAFAYETTE**

(Licensed Embalmer's Signature on Reverse Side)

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

**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 *R. P. Cooper*.....

Licensed Embalmer No. *363*  
P. O. Address *2317 Lajava*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.