

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-009603  
STATE FILE NUMBER

FILED APR 15 1958

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 355C

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| 1. PLACE OF DEATH<br>a. COUNTY <u>Greene</u>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo.</u> b. COUNTY <u>Dallas</u> |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Springfield</u>              |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   | c. CITY OR TOWN <u>0300</u><br>Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>Burge Hospital</u> |  | Length of stay in lb <u>20 hrs</u>   | d. STREET ADDRESS (If outside, give location)<br><u>Tunas, Mo.</u><br>Reside on Farm<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print)<br>First <u>Mary</u> Middle <u>IVY</u> Last <u>SKinner</u> |  |  | 4. DATE OF DEATH<br>Month <u>April</u> Day <u>2</u> Year <u>1958</u> |  |  |
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|----------------------|-------------------------------|---|--------------------------------------|---|---|--|
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>NOV. 5, 1905</u> | 9. AGE (In years last birthday) <u>52</u> | IF UNDER 1 YEAR<br>Months <u>4</u> Days <u>28</u> | IF UNDER 24 HRS.<br>Hours <u></u> Min. <u></u> |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>House wife</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> | 11. BIRTHPLACE (City and state or country)<br><u>Dallas Co. MO.</u> | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u> |
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| 13a. FATHER'S NAME<br><u>AL Fred paynter</u> | 13b. MOTHER'S MAIDEN NAME<br><u>Unknown</u> | 14. NAME OF HUSBAND OR WIFE<br><u>Robert Skinner</u> |
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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)<br><u>no</u> | 16. SOCIAL SECURITY NO. <u>-</u> | 17. INFORMANT (Name and Address)<br><u>Robert Skinner Tunas, Mo.</u> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Central Hemorrhage</u> |                                  | INTERVAL BETWEEN ONSET AND DEATH  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.   | DUE TO (b) <u>Vasculitis</u>     |   |
|  | DUE TO (c) <u>4 hypertension</u> |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><u>331X</u>           |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

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| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) |
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|   |   |  |                              |        |       |
|---|---|--|------------------------------|--------|-------|
| 20c. TIME OF INJURY<br>Hour <u></u> Month, Day, Year <u></u><br>a.m. <u></u> p.m. <u></u> | 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION | COUNTY | STATE |
|---|---|--|------------------------------|--------|-------|

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| 21. I attended the deceased from <u>April 1/58</u> to <u>April 2/58</u> and last saw her alive on <u>April 2/58</u><br>Death occurred at <u>3:30 a.m. 4/2/58</u> m on the date stated above; and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE (Deceased or title)<br><u>W A Deibel Sr</u> | 22b. ADDRESS<br><u>Springfield Mo</u> | 22c. DATE SIGNED<br><u>4/4/58</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u> | 23b. DATE<br><u>4/4/1958</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Hope Well Cem.</u> | 23d. LOCATION (City, town, or county) (State)<br><u>Dallas Co. Mo.</u> |
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| 24. FUNERAL DIRECTOR<br><u>Montgomery Funeral Home</u> | ADDRESS<br><u>Buffalo, Mo.</u> | 25. DATE RECD. BY LOCAL REG.<br><u>4-7-58</u> | 26. REGISTRAR'S SIGNATURE<br><u>Effie G. Melton</u> |
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

VIS  
MAR 23 1900

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 *Blyde Montgomery* .....

Licensed Embalmer No. *3592* .....

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