

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-020156
STATE FILE NUMBER
5707

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5707

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Arkansas b. COUNTY Sebastian	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		c. CITY OR TOWN Fort Smith 8030g	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR St. Louis Little Rock Hosp, Inc		d. STREET ADDRESS (If outside, give location) 818 North 34th Street	
Length of stay in lb 41 days		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Wilfred , Middle Aubrey , Last Skinner	4. DATE OF DEATH Month May , Day 30 , Year 1958
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 31, 1895	9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief Clerk	10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (City and state or country) Merouze, Louisiana.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME William Albert Skinner	13b. MOTHER'S MAIDEN NAME Henrietta Schneider	14. NAME OF HUSBAND OR WIFE Clara Skinner
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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)	16. SOCIAL SECURITY NO. 702-14-0874	17. INFORMANT Address Clara Skinner, 818 N. 34th, Fort Smith, Ark.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion Cancer Larynx DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	INTERVAL BETWEEN ONSET AND DEATH
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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 Hour _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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 April 19, 1958 to May 30, 1958 and last saw her/him alive on May 30, 58 Death occurred at 11:20 pm on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE X Francis X. Palotta MD	22b. ADDRESS 1755 South Grand Ave.	22c. DATE SIGNED 5-31-58
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 5-31-58	23c. NAME OF CEMETERY OR CREMATORY Riverside Cemetery	23d. LOCATION (City, town, or county) (State) Monroe, Louisiana.
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24. FUNERAL DIRECTOR Albert H. Hoppe, 4700 Washington Blvd.,	25. DATE RECD. BY LOCAL REG. JUN 2 '58	26. REGISTRAR'S SIGNATURE Carol Smith MD
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Elmo R. Cadu*
Licensed Embalmer No. *407*
P. O. Address *St. Louis*

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.