

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-044860  
STATE FILE NUMBER

FILED DEC 17 1958 Registration District No. 200 Primary Registration District No. 3041 Registrar's No. 122

S. 300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Macon</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Macon</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Macon</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Macon</b> <b>06110</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>419 E. Main</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>419 E. Main</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>ARTHUR CEMORE SKINNER</b>			4. DATE OF DEATH Month Day Year <b>Dec. 1 1958</b>
5. SEX <b>Male 0</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 24, 1874</b>
9. AGE (In years last birthday) <b>84</b>		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) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (City and state or country) <b>Macon County Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>William R. Skinner</b>	13b. MOTHER'S MAIDEN NAME <b>Sarah Sneed</b>
14. NAME OF HUSBAND OR WIFE <b>Mollie Waller Skinner</b>		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>49 2-12-3609</b>
17. INFORMANT <b>Mrs. Elmer Burton</b>		Address <b>Macon, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 wks.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerosis - Hypertension.</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
DUE TO (c) <b>331X</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Chronic Thyroiditis - Acute hemorrhagic</b>			
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.)	
20c. TIME OF INJURY Hour Month, Day, Year 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	
21. I attended the deceased from <b>1934</b> to <b>Dec 1, 1958</b> and last saw him alive on <b>Dec 1, 1958</b> Death occurred at <b>10:30 a</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>R. Lester Brown</b> (Degree or title)		22b. ADDRESS <b>Macon</b>	
22c. DATE SIGNED <b>12/2/58</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/3/1958</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Friendship</b>		23d. LOCATION (City, town, or county) (State) <b>Macon Missouri</b>	
24. FUNERAL DIRECTOR <b>R. Lester Brown</b> ADDRESS <b>Macon, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>12/12/58</b>	
26. REGISTRAR'S SIGNATURE <b>Ruth Mueely</b>			

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

No symptoms will be listed.

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 *E. Beckwith* .....

Licensed Embalmer No. .... 322

P. O. Address *Mason* .....

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.