

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-001029

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 104

FILED FEB 9 1959

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1-57

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Christian</u>	
b. CITY OR TOWN <u>Springfield</u> (If outside corporate limits, give TOWNSHIP only) Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Billings</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Burge Hosp.</u>		d. STREET ADDRESS (If outside, give location) <u>no street address</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Length of stay in lb <u>1 day</u>			

3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>MARGARET</u> Last <u>SKEA</u>			4. DATE OF DEATH Month <u>Jan.</u> Day <u>29</u> Year <u>1959</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"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 4, 1893</u>	9. AGE (In years last birthday) <u>66</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>- - - -</u>	11. BIRTHPLACE (City and state or country) <u>Urbana, Ohio</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
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13a. FATHER'S NAME <u>Peter Rauch</u>	13b. MOTHER'S MAIDEN NAME <u>Caroline Winters</u>	14. NAME OF HUSBAND OR WIFE <u>Chas. R. Skea</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) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT Address <u>Mr. Chas. R. Skea, Billings, Mo.</u>
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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) <u>Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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) <u>331X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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 WORK <input type="checkbox"/> NOT 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>Jan 28, 1959</u> to <u>Jan 29, 1959</u> and last saw him alive on <u>Jan 28, 1959</u> Death occurred at <u>5:55 a.</u> on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) <u>James I. Good md.</u>	22b. ADDRESS <u>Springfield, Mo.</u>	22c. DATE SIGNED <u>1-31-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2/1/1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wise Hill Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Clever, Missouri</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Jean Harris, Clever, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>2-4-59</u>	26. REGISTRAR'S SIGNATURE <u>Effie E. Melton</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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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 *J. Sean Harris* .....

Licensed Embalmer No. *4390* .....

P. O. Address *Cleveland, 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.