

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-012038  
STATE FILE NUMBER

FILED MAR 23 1959

Registration District No. 357 Primary Registration District No. 4517 Registrar's No. 29

300  
-57

1. PLACE OF DEATH a. COUNTY <u>TANEY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>TANEY</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>BRANSON</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Point Lookout</u> 1060 Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Skaggs Hosp.</u>		Length of stay in 1b <u>4 Wks</u>	d. STREET ADDRESS (If outside, give location) <u>School of Ozarks</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Thomas STANLEY SKINNER</u>			4. DATE OF DEATH Month Day Year <u>MARCH 18, 1959</u>
5. SEX <u>male</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>MAY 1, 1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MUSIC</u>	9. AGE (In years last birthday) <u>76</u> IF UNDER 1 YEAR Months Days <u>10 17</u> IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (City and state or country) <u>Princeton, Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Thomas SKINNER</u>		13b. MOTHER'S MAIDEN NAME <u>WILIE ANNA SKINNER</u>	14. NAME OF HUSBAND OR WIFE <u>Vera SKINNER</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no none</u>		16. SOCIAL SECURITY NO. <u>489-36-8340</u>	17. INFORMANT <u>Mad Thomas Skinner Springfield, Mo</u> Address <u>2127 N. main</u>
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>Uremia</u> Conditions, if any, which gave rise to above cause (a), starting the underlying cause last. } DUE TO (b) <u>Nephra sclerain, + bloodied arteriosclerosis</u> DUE TO (c) <u>Hypertension Essential</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 Wks</u> <u>Yrs -</u> <u>Yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) <u>446x</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>
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 WORK <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 <u>Oct. 1953</u> to <u>3-18-59</u> and last saw him alive on <u>3-18-59</u> Death occurred at <u>3-18-59 at 10:45 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>W. C. Magnus, M.D.</u>		22b. ADDRESS <u>BRANSON, Missouri</u>	22c. DATE SIGNED <u>3-19-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3/21/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Seatons Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Springfield, MO</u>
24. FUNERAL DIRECTOR ADDRESS <u>Whitcheel Funeral Chapel Branson, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>3-20-59</u>	26. REGISTRAR'S SIGNATURE <u>Helew Campbell</u>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Walter S. Cobb*

Licensed Embalmer No. *4731*  
P. O. Address *Long St, 7*

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.