

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-018568  
STATE FILE NUMBER

300  
-57

JUN 15 1959 Registration District No. 221 Primary Registration District No. \_\_\_\_\_ Registrar's No. 161

1. PLACE OF DEATH a. COUNTY <u>Nodaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Nodaway</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Barnard</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Barnard</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>Home</u> Length of stay in 1b <u>45 yrs.</u>		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES GORDON SKIDMORE</u>			4. DATE OF DEATH Month Day Year <u>May 30, 1959</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc.</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>19 March, 1877</u>
9. AGE (In years) <u>82</u> (Last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>postmaster near Guilford, Mo.</u>		11. BIRTHPLACE (City and state or country) <u>USA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Joseph Skidmore</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Ann Thompson</u>	
14. NAME OF HUSBAND OR WIFE <u>Effie Minnie Dougan</u>		14. NAME OF HUSBAND OR WIFE <u>Effie Minnie Dougan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (es, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Effie A. Skidmore, Barnard, Mo.</u>		17. INFORMANT <u>Mrs. Effie A. Skidmore, Barnard, Mo.</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>Sctus caechi</u>			INTERVAL BETWEEN ONSET AND DEATH <u>momentary</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____			334XH
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>Carcinoma of rectum; permanent colostomy, March, 1946</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 a.m. p.m. Month, Day, Year		20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT <input type="checkbox"/> WORK		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>15 Oct, 1945</u> to <u>30 May, 1959</u> and last saw him alive on <u>23 March, 1959</u> Death occurred at <u>9:25 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>Chas. J. Humboldt</u>		22b. ADDRESS <u>Barnard, Mo.</u>	
22c. DATE SIGNED <u>5/31/59</u>		22c. DATE SIGNED <u>5/31/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>6-2-1959</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Masonic Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Barnard, Mo.</u>	
24. FUNERAL DIRECTOR <u>Whitson Funeral Home, Mayville, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>6-11-59</u>	
26. REGISTRAR'S SIGNATURE <u>Bess Holt</u>		26. REGISTRAR'S SIGNATURE <u>Bess Holt</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

JUL 10 1956

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 *G M Atchison* .....

Licensed Embalmer No. *2279*  
P. O. Address *Maryville*

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.