

**FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-035893**

FILED VS OCT 19 1959

STATE FILE NUMBER

Registration District No. 2728 Primary Registration District No. 2090 Registrar's No. 1079

UNDECEASED

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Lawrence</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) ON TOWN <u>Springfield</u>		Length of stay in 1b <u>4 mos.</u>	c. CITY OR TOWN <u>Mt. Vernon</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>Mercy Infirmary</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>So. Hickory</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Stella</u> Middle <u>Elizabeth</u> Last <u>Skinner</u>			4. DATE OF DEATH Month <u>October</u> Day <u>10</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>4-29-1977</u>	9. AGE (last birthday) <u>82</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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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	11. BIRTHPLACE (City and state or country) <u>Stotts City Mo. Law. Co.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>C.R. Shelton</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Ellis</u>	14. NAME OF HUSBAND OR WIFE <u>John Skinner</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)	16. SOCIAL SECURITY NO. _____	17. INFORMANT Address <u>Marie Hailey - Mt. Vernon, 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>LOBAR PNEUMONIA</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</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)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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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. Month, Day, Year _____
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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 <u>Springfield, Mo.</u>	COUNTY _____ STATE _____
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21. I attended the deceased from SEPT 1, 1959 to OCT 10, 1959 and last saw her/him alive on OCT 10, 1959  
Death occurred at 2:10 PM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>L. Richard Webb, M.D.</u>	22b. ADDRESS <u>609 Cherry St Springfield, Mo.</u>	22c. DATE SIGNED <u>10-10-59</u>
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23a. BURIAL, CREMATION, REINTERMENT (Specify) <u>Burial</u>	23b. DATE <u>10-13-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>1007 Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Mt. Vernon - Law. Co. - Mo.</u>
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24. FUNERAL DIRECTOR <u>May L. Fossett - Mt. Vernon, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>10-13-59</u>	26. REGISTRAR'S SIGNATURE <u>Effie S. Meerton</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MAY 1 0 1961

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 Max R. Fossett

Licensed Embalmer No. 4252

P. O. Address McVernon

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.