

318

1003

9155

STATE FILE NUMBER

AMENDED

Registration District No. **FILED OCT 13 1961**

Primary Registration District No.

Registrar's No.

DATE AMENDED

INSTEAD OF THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY <b>Marion</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		c. CITY OR TOWN <b>Central City</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <b>BARNES HOSPITAL</b>		d. STREET ADDRESS (If outside, give location) <b>238 Douglas Street</b>	

3. NAME OF DECEASED (Type or print) First <b>CHESTER</b> Middle <b>GRANT</b> Last <b>SKIPPER</b>			4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>30</b> Year <b>1961</b>		
5. SEX <b>Male</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>7/13/1901</b>	9. AGE (last birthday) <b>60</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fuel Oil Dist.</b>		11. BIRTHPLACE (City and state or country) <b>Central City, Illinois</b>	
12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>		13a. FATHER'S NAME <b>Grant Skipper</b>		13b. MOTHER'S MAIDEN NAME <b>Elizabeth Walmboldt</b>	
14. NAME OF HUSBAND OR WIFE <b>Ethel Skipper</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. 17. INFORMANT				Address	

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>BONE MARROW FAILURE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1-1 1/2 MONTHS</b>
DUE TO (b) <b>POLYCYTHEMIA VERA</b>		<b>4 YEARS</b>
DUE TO (c) <b>294x</b>		

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 checked="" type="checkbox"/> NO <input 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.)	
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 **SEPT. 22, 1961** to **SEPT. 30, 1961** and last saw her/him alive on **SEPT. 30, 1961**  
Death occurred at **10:20 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>F R Bradley MD F. R. BRADLEY, M. D.</b>	22b. ADDRESS <b>BARNES HOSPITAL</b>	22c. DATE SIGNED <b>10/1/61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Oct. 3, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Memorial Park</b>	23d. LOCATION (City, town, or county) (State) <b>Sandoval Twp, Marion Co. Ill</b>
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24. FUNERAL DIRECTOR <b>Galbreath Funeral Home</b>	ADDRESS <b>Centralia, Illinois</b>	25. DATE RECD. BY LOCAL REG. <b>OCT 4 1961</b>	26. REGISTRAR'S SIGNATURE <b>Loard Smith M.D.</b>
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**STATEMENT BY LICENSED EMBALMER**

**Not embalmed in Missouri. Galbreath Funeral Home, Paul A. Keith, Owner. Missouri Lic**

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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.