MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Mercer

Township Marion
or
Village
or
City (NO. St.; Ward)

Registration District No. 553 File No. 25293

Primary Registration District No. 5746 Registered No. 25

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Elizabeth Sarah McKinney

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Widowed

DATE OF BIRTH: May (Month) 26 (Day), 1837 (Year)

AGE: 74 yrs. 1 mos. 15 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): 1-22

BIRTHPLACE (City or town, State or foreign country): Mo.

PARENTS
NAME OF FATHER: Geo. Butts
BIRTHPLACE OF FATHER (City or town, State or foreign country): Not Known
MAIDEN NAME OF MOTHER: Jemima Blake
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Not Known

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Carl M. McKinney

(ADDRESS) Mercer Mo.

Filed 7-14, 1911. C. P. Pickett REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: July (Month) 11 (Day), 1911 (Year)

I HEREBY CERTIFY, that I attended deceased from Apr 1, 1911, to July 11, 1911, that I last saw her alive on June 30, 1911, and that death occurred, on the date stated above, at 1:30 P m.

The CAUSE OF DEATH* was as follows:

Scirrhosis of Liver

1248

92 [illegible]

(Duration) 2 yrs. ___ mos. ___ ds.

Contributory (SECONDARY) Endocarditis

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) B. S. Powell M. D.

July 14, 1911 (Address) Princeton

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Mercer Co. (McKinney Cemetery)

DATE OF BURIAL: July 12, 1911

UNDERTAKER: O. O. Greenlee

ADDRESS: Lineville, Ia

Revised United States Standard Certificate of Death

MISSOURI STATE BOARD OF HEAL
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CERTIFICATE OF DEATH

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....

or

Village ..... Primary Registration District No. ..... Registered No. .....

or

City ..... (NO. ....., ... St.; ..... Ward)

[If death occurred hospital or institu give its NAME in of street and numbe

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

..... (Month) ..... (Day), 1..... (Year)

AGE

..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ....., 191..., ...

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

..... (Month) ..... (Day), 1

I HEREBY CERTIFY, that I attended deceased

....., 191...., to ....., 1

that I last saw h..... alive on ....., 1

and that death occurred, on the date stated above, at .....

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) ..... yrs. ..... mos. .....

Contributory .....
(SECONDARY)

..... (Duration) ..... yrs. ..... mos. .....

(Signed) .....

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Cause (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIE RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. .....

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	.....
UNDERTAKER	ADDRESS