

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH
County Monroe
Township Marion
or
Village
or
City

Registration District No. 579
Primary Registration District No. 5776B
File No. 31843-C
Registered No. 31
St. Ward

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

FULL NAME Amanda E. McKinney

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Widowed
(Write the word)
DATE OF BIRTH Feb. 9, 1850
(Month) (Day) (Year)

DATE OF DEATH Sept 26, 1916
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 1, 1915, to Sept 26, 1916, that I last saw her alive on Sept 25, 1916, and that death occurred, on the date stated above, at _____ m.

AGE 66 yrs. 7 mos. 16 ds.
If LESS than 1 day, ____ hrs. or ____ min.?

The CAUSE OF DEATH* was as follows:

OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
At Home

Cancer uterus
(Duration) ____ yrs. ____ mos. ____ ds.

BIRTHPLACE
(City or town, State or foreign country)
Monroe Co Mo

Contributory
(SECONDARY)
(Duration) ____ yrs. ____ mos. ____ ds.

PARENTS
NAME OF FATHER Hugh Grimes
BIRTHPLACE OF FATHER (City or town, State or foreign country) Virginia
MAIDEN NAME OF MOTHER Francis Blaine
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo

(Signed) W. E. Johnson M. D.
Sept 26 1916 (Address) Madison Mo

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. A. McKinney
(ADDRESS) Madison Mo

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.

Filed 9/26, 1916
W. E. Johnson Deputy Registrar
W. E. Johnson Registrar

PLACE OF BURIAL OR REMOVAL Marion Cemetery
DATE OF BURIAL 9/27, 1916
ADDRESS Madison Mo

PLACE OF DEATH

County

Township

or

Village

or

City

Registration District No.

File No.

Primary Registration District No.

Registered No.

(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 (if file the word)
DATE OF BIRTH	(Month)	(Day) (Year)
AGE	YRS.	mos. ds.
OCCUPATION	IF LESS than 1 day, hrs. or min.?	

(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)

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) 19 (Day) 19 (Yr)

I HEREBY CERTIFY, that I attended deceased

191, to 191,

that I last saw h. alive on 191

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

The CAUSE OF DEATH was as follows:

Contributory
(Secondary)

(Duration) yrs. mos.

(Duration) yrs. mos.

(Signed)

191 (Address)

M

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

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

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

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL 191

UNDERTAKER

ADDRESS

Township or Village or City

Registration District No.

Primary Registration District No.

File No.

Registered No.

St. Ward

If death occurred in a hospital or institution.

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