

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

Do not use this space.

26975

1. PLACE OF DEATH
 County Sneads Registration District No. 318
 Township _____ Primary Registration District No. 2001
 City Springfield (No. _____) St. _____ Ward _____

2. FULL NAME Clyde McKinney
 (a) Residence. No. Bucyrus Mo. St. _____ Ward. _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

File No. _____
 Registered No. 569

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 20 1915

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
12 Unknown

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work School Boy
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Texas Co Mo

10. NAME OF FATHER James McKinney

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) MO

12. MAIDEN NAME OF MOTHER Eda Harmon

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) MO

14. INFORMANT James McKinney
 (Address) Bucyrus Mo

15. FILE NO. 917 REGISTRAR O. Horst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 17 1927

17. I HEREBY CERTIFY, That I attended deceased from Aug 28, 1927, to Sept 17, 1927 that I last saw him alive on Sept 16, 1927, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
accidental injury, dropped by a horse for 1/4 of mile, struck self completely off of skull & otherwise destroying body. (duration) yrs. mos. 20 ds.

CONTRIBUTORY (SECONDARY) Blood stream infection
2 1/2 M (duration) yrs. mos. 18 ds.

18. WHERE WAS DISEASE CONTRACTED? Texas County
 IF NOT AT PLACE OF DEATH, _____
 DID AN OPERATION PRECEDE DEATH? yes Repair of scalp DATE OF _____
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS? supp
 (Signed) J. J. Lewis M. D.
 _____, 19 (Address) SPRINGFIELD, MO

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Cabool Mo DATE OF BURIAL 9/18 1927

20. UNDERTAKER Finney ADDRESS Oliver Lohmeyer Home Springfield Mo

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

