

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

Do not use this space.

30440

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township Kaw Primary Registration District No. 199 1002
 City Kansas City (No. Simpson-Major Sanitarium) St. _____ Word _____

File No. _____
 Registered No. 247

2. FULL NAME Mrs. Laura McKinney

(a) Residence. No. 2621 East 34th St. St. _____ Ward. _____
 (Usual place of abode)
 Length of residence in city or town where death occurred yrs. mos. _____
 How long in U.S., if of foreign birth? yrs. mos. ds. 4 11

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 5, 1849

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
79 1 14

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home
 (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) Ind.

10. NAME OF FATHER Allen Palmer

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) don't know

12. MAIDEN NAME OF MOTHER Evaline Campbell

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) don't know

14. INFORMANT Miss Rena McKinney (Address) 2621 E 34th St.

15. FILED 10/19/27 M. M. Corwin REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Oct 12, 1927, to Oct 19, 1927, that I last saw her alive on Oct 18, 1927, and that death occurred, on the date stated above, at 1:05 p m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

apoplexy (cerebral hemorrhage)
87H
99 (duration) _____ yrs. _____ mos. 3 ds.

CONTRIBUTORY arteriosclerosis (SECONDARY) (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE AND HOW DISEASE CONTRACTED 7401 (duration) _____ yrs. _____ mos. _____ ds.
 IF NOT AT PLACE OF DEATH don't know

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

19. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? clinical
 (Signed) Herman S. Mason M. D.

10/19, 1927 (Address) 3400 Euclid KCMO

*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 Geneseo, Ill DATE OF BURIAL 10/20/27

20. UNDERTAKER The Freeman Mortuary 42nd & Baltimore ADDRESS _____

WHILE FULFILLING DUTY WITH UNPAID INK THIS IS A PERMANENT RECORD

I. B.—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.

U. S. ...
... ..