

7 191 09 23 1928

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

Do not use this space.

1976

1. PLACE OF DEATH
 County St. Louis Registration District No. 1046
 Township Shelburne Primary Registration District No. 5810
 City Springfield (No. _____) St. _____ Ward _____
 File No. _____
 Registered No. 6

2. FULL NAME Thomas Jefferson McKinney
 (a) Residence No. _____ 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF Florence McKinney

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 7/00 23 - 1855

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
73 | 1 | 13 | _____

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

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 16 1928

17. I HEREBY CERTIFY That I attended deceased from Jan 10 1928, to Jan 16 1928 that I last saw her alive on Jan 16 1928, and that death occurred, on the date stated above, at 11 9 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

11
Pneumonia
109 (duration) yrs. mos. da.
 CONTRIBUTORY (SECONDARY) 10/12 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH _____
 8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS _____
 (Signed) W. H. Schaefer, M.D.
1/17, 19 (Address) Springfield

*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.

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Peoria

10. NAME OF FATHER Robert McKinney

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

12. MAIDEN NAME OF MOTHER _____

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

14. INFORMANT (Address) W. H. Jackson
Springfield

15. FILED 1/17, 19 28 J. W. Thomas REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Jackson DATE OF BURIAL 1/17 1928

20. UNDERTAKER W. H. Jackson ADDRESS Springfield

N. 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.

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