

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

Do not use this space.

1. PLACE OF DEATHCounty TexasRegistration District No. 865File No. 2026191Township CassPrimary Registration District No. 643

Registered No. _____

City Waco (No. _____)

St. _____ Ward _____

2. FULL NAMEAly McKinney

(a) Residence. No. _____ St. _____ Ward _____ (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**Male**4. COLOR OR RACE**White**5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)**married**5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF**Mrs Mary McKinney**6. DATE OF BIRTH (MONTH, DAY AND YEAR)****7. AGE**

YEARS

MONTHS

DAYS

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

79627**8. OCCUPATION OF DECEASED**

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

Farmer

(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)

Missouri**10. NAME OF FATHER**Andy McKinney**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

Tennessee**12. MAIDEN NAME OF MOTHER**William**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

Franklin Tennessee**14. INFORMANT**

(Address)

Mrs. Aly McKinney**15. FILE**

No. _____

July 20, 1928

REGISTRAR

MEDICAL CERTIFICATE OF DEATH**16. DATE OF DEATH (MONTH, DAY AND YEAR)**July 13 1928**17.**

I HEREBY CERTIFY, That I attended deceased from _____

that I last saw him alive on _____, 1928, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Carcinoma of Larynx**CONTRIBUTORY (SECONDARY)****18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)

W. H. Herron

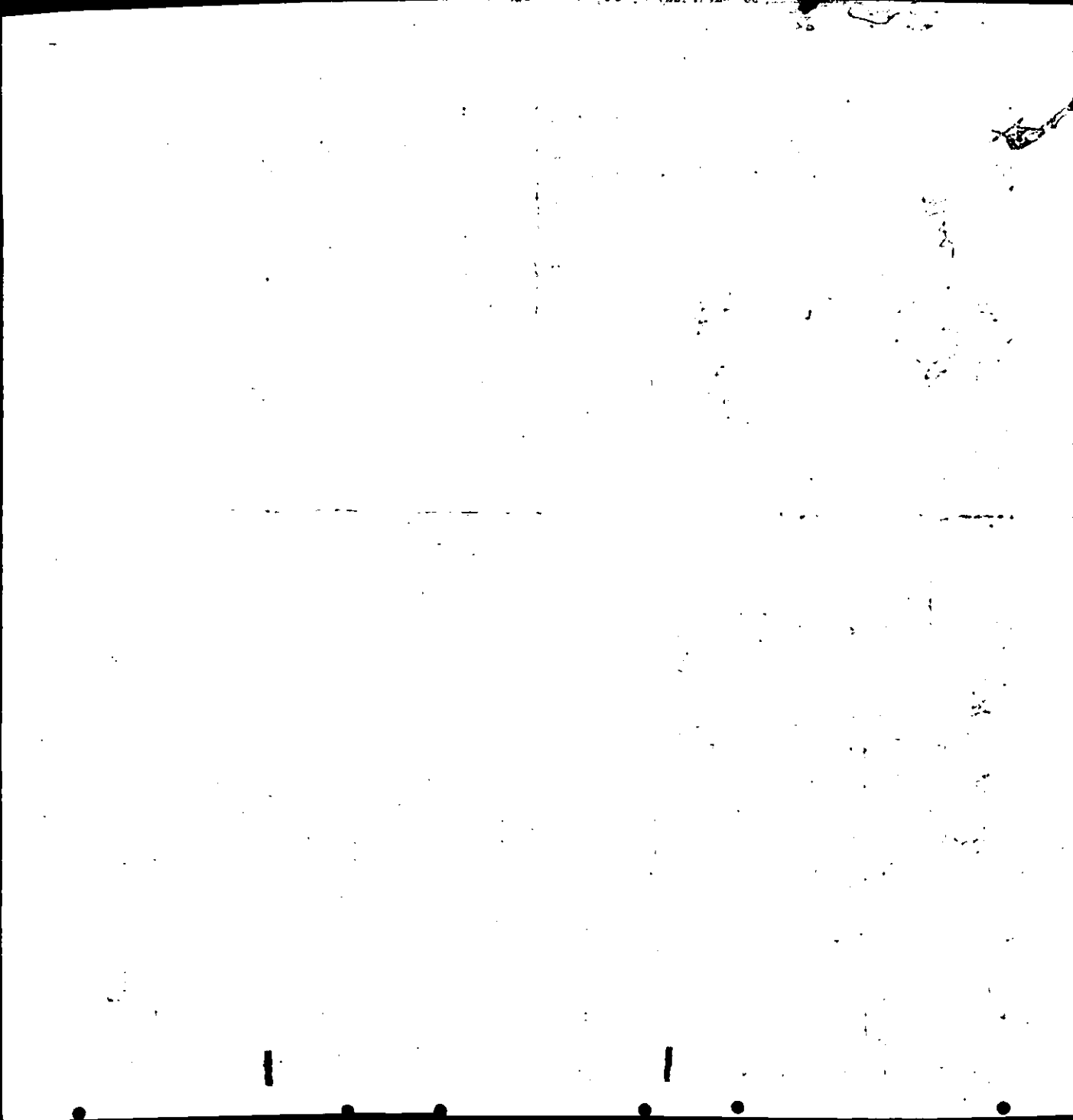
M. D.

(Address)

Houston, 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**DATE OF BURIAL**Graves CemeteryJuly 14, 1928**20. UNDERTAKER****ADDRESS**Dayton V. EllisCalhoun



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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Texas
Township Clark
City (No.)

Registration District No. 865-
Primary Registration District No. 6143

File No. 20
Registered No.
St. Ward

2. FULL NAME

(a) Residence. No. Aly McKinney 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.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 16 - 1849

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
79 6 27

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work
(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)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT (Address)

15. July 20, 1928 Robert Hubbard REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 13 1928

17. I HEREBY CERTIFY That I attended deceased from 19, that I last saw him alive on, 19, and that death occurred, on the date stated above, at

THE CAUSE OF DEATH WAS AS FOLLOWS:

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH DATE OF

WAS THERE AN AUTOPSY

WHAT TEST CONFIRMED DIAGNOSIS

(Signed), M. D.
, 19 (Address)

*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 DATE OF BURIAL

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-26191