

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

Do not use this space.

34135

1. PLACE OF DEATH

County Lumpkin Registration District No. 5-12 File No. _____
 Township _____ Primary Registration District No. 5-6-85 Registered No. 20
 City Wixca (No. _____) St. _____ Ward _____

2. FULL NAME McKinley Brown Jr.

(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 Male 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED OR DIVORCED LS
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND or (or) WIFE of ✓

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 8 1928

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
6 13

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) Wixca (STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER McKinley Brown
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Breckenridge Mo
 12. MAIDEN NAME OF MOTHER Mable Harris
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Hamilton Mo

14. INFORMANT McKinley Brown (Address) Wixca Mo

15. FILED Apr 22 1928 Dana L Cooper REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10 21 1928

17. I HEREBY CERTIFY That I attended deceased from _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at 6:30 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Suffocation - Accidental

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? NO DATE OF _____ WAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) Alfred Collier, M. D. 0022 1928 (Address) Chickasha Okla

*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 Hamilton Cem DATE OF BURIAL 10 23 1928

20. UNDERTAKER FB Norman Chickasha Mo ADDRESS _____

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.

1928

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Luzhington
Township Greene
City (No.) St. Ward)

Registration District No. 512
Primary Registration District No. 5682

File No.
Registered No. 20

2. FULL NAME

McKinley Brown Jr

(a) Residence. No. St. Ward.
(Usual place of abode)

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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

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

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.

FILED Jan 12 1929 Anna R. Carpenter REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10 - 21 19 28

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

Aspiration - accidental
Red band wrapped too tightly
in stomach with trunk, while riding in
taxi cab. (duration) yrs. mos. ds.

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

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

SUPPLEMENTARY

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