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

Do not use this space.

1743

1. PLACE OF DEATH
County Jackson — Registration District No. 399 — File No.
Township City — Primary Registration District No. 1902 — Registered No. 335
City Kansas City, Mo (No. General Hosp.) St. Ward)

2. FULL NAME McKinney, Richard

(a) Residence. No. 1717 Lydia St., 4 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 1 1871

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	0	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Common Laborer
(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) Colo

PARENTS

10. NAME OF FATHER Wm McKinney
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Colo
12. MAIDEN NAME OF MOTHER Mary Ellen ?
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Ills

14. INFORMANT Kirkwood Hosp. #2
(Address) 24th & Cherry St.

15. FILED 1-23-29 M. M. Crane Asst REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1/2 1929

17. I HEREBY CERTIFY, That I attended deceased from 12/26, 1928, to 1/2, 1929, that I last saw h[illegible] alive on 1/2, 1929 and that death occurred, on the date stated above, at 1:30 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Tuberculosis
29A
495
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Myocardial Dilatation
(duration) yrs. mos. ds.

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) H. M. Grant, M. D
1/3, 1929 (Address) K. C. Gen. Hosp #2

*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
Leeds Mo.	1-26 1929
20. UNDERTAKER H. B. Moore	ADDRESS 1820 E 18th

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.