

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

Do not use this space.

10344
6

1. PLACE OF DEATH

County Greene
Township Cuba
City _____ (No. _____)

Registration District No. 820
Primary Registration District No. 6443

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Hel Dapha Dena M. Kinney

(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 female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug-29-1894

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
38 6 24 _____ _____ _____

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) Bris Dena Mo
(STATE OR COUNTRY)

10. NAME OF FATHER Andrew M. Kinney

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

12. MAIDEN NAME OF MOTHER Annanda Harris

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

14. INFORMANT Mrs. Dena Buckow
(Address) Bour Dena Mo

15. FILED 3/24, 1929 Lucy E. Hayes
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 23 1929

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Sodium Fluoride Poisoning
163x 166 166
163x 166 166
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 166
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH? Yes DATE OF _____

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) Thomas C. Stone, Cooper, M. D.

Mar 23, 1929 (Address) Springfield, 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 Clear Creek Cemetery

DATE OF BURIAL 3/25 1929

20. UNDERTAKER Pullman Hayes

ADDRESS Bour Dena

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**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 Greene
Township Center
City _____ (No. _____ St. _____ Ward)

Registration District No. 320
Primary Registration District No. 3443

File No. 10344
Registered No. 6

2. FULL NAME

Deepa Derna 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 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) Aug 29-1891

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
37 6 24

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 _____, 19 Aug 2, 1901 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 23 1929

17. I HEREBY CERTIFY That I attended deceased from _____ to _____, 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:

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

Every item of information on this certificate 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

5-10344