

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

Do not use this space.

13402

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City **St. Louis** (No. **000000**) St. **Ward**

File No.....
 Registered No. **4075**

2. FULL NAME

Phillip McKenney
 (a) Residence. No. **1119 Brooklyn** No. Ward.....
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred **6** 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 **W** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Married**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Dec 25, 1878**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
51 / 3 / 3

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Fireman**
 (b) General nature of industry, business, or establishment in which employed (or employer) **St. Louis Commonwealth**
 (c) Name of employer **Steel Coy. Claud Cross**

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Miss**

10. NAME OF FATHER **Frank McKenney**

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

12. MAIDEN NAME OF MOTHER **Anna McKenney**

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

14. INFORMANT **E. Easter McFarland**
 (Address) **Sherard Miss**

15. APR - 5 1929
 FILED **Wm C Farley** REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **3-28 1929**

17. I HEREBY CERTIFY That I attended deceased from **Feb. 12 1929** to **3/28/29** and that I last saw him alive on **3/28/29** death occurred, on the date stated above, at **131 92nd** in.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Chronic Int. Nephritis. Mitral regurgitation.

CONTRIBUTORY (SECONDARY) **129 W**

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? **no**

19. DID AN OPERATION PRECEDE DEATH? **no** DATE OF.....

20. WAS THERE AN AUTOPSY? **no**

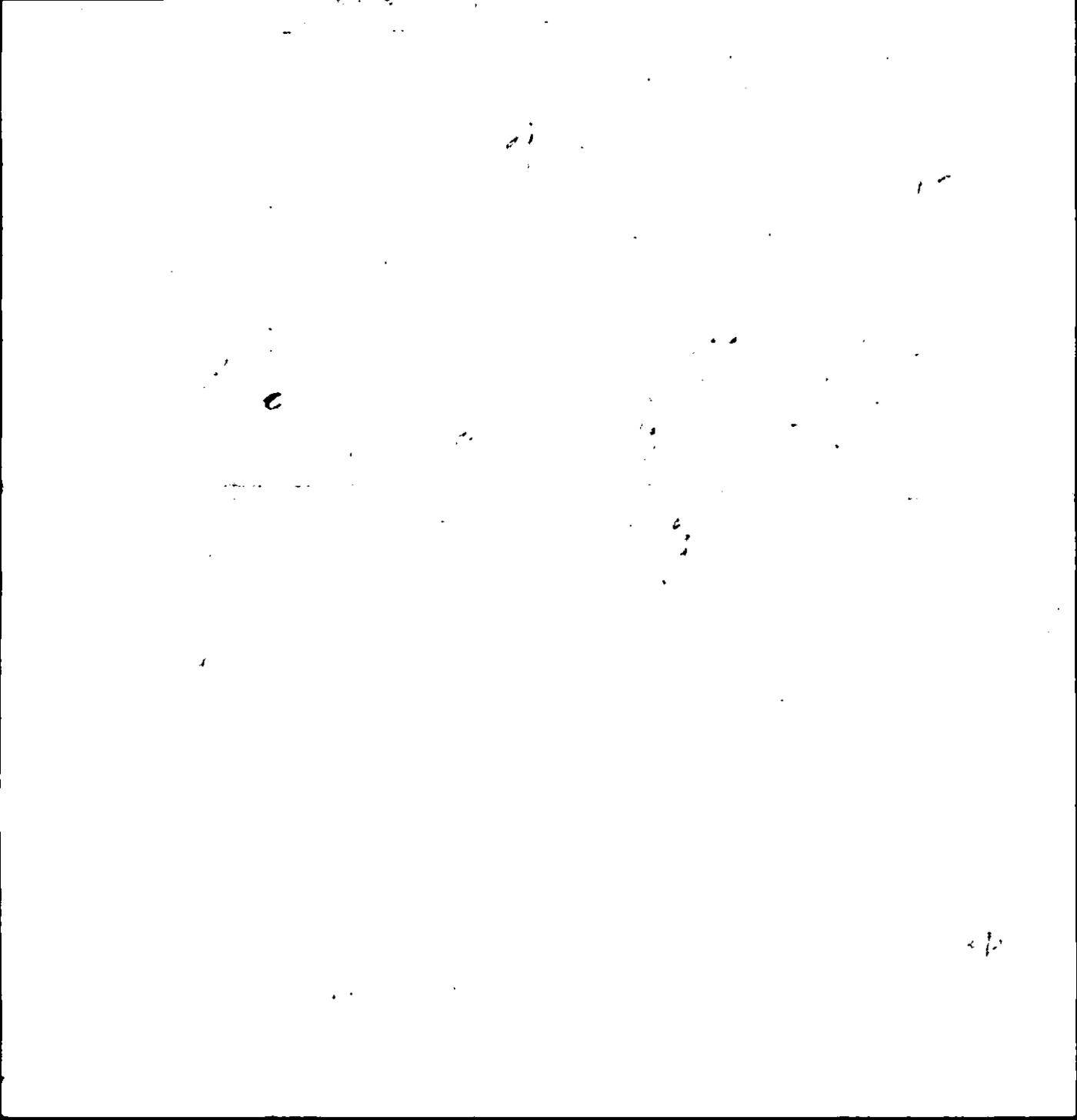
21. WHAT TEST CONFIRMED DIAGNOSIS? **Clinical**

(Signed) **L. W. Hirsch** M.D.
 (Address) **2005 Mon**

22. 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 **Sherard Miss** DATE OF BURIAL **4-7 1929**

23. UNDERTAKER **H. B. Green** ADDRESS **3517 Sacke**



**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..... Registration District No. 791
Township..... Primary Registration District No. 1003
City St. Louis (No.)

File No. 13402
Registered No. 4103
St. 407V Ward

2. FULL NAME

(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 (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 25-1878

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
50 3 3

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)

PARENTS

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 JUL - 8 - 1929 Maxe Stander REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8/28 1929

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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)....., 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

C. M. C. Green

LET AS PRESCRIBED LAW REGISTRATION SHALL OF RECEIVE A FEE FOR CERTIFICATES UNTIL

S-13402