

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

Do not use this space.

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City St. Louis (No. 3308) Williams Pl St. _____ Ward)

35060
 File No. _____
 Registered No. **9769**
 St. _____ Ward)

2. FULL NAME

Ray Mc Kinney
 (a) Residence. No. 3308 Williams Pl _____ 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 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 Annie Mc Kinney
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 27, 1893
 7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
36 3 4

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work. Painter
 (b) General nature of industry, business, or establishment in which employed (or employer).
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)..... Searcy
 (STATE OR COUNTRY) Ark.

PARENTS
 10. NAME OF FATHER Walter Mc Kinney
 11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... Hamterville
 (STATE OR COUNTRY) Ind.
 12. MAIDEN NAME OF MOTHER Jenny Parks
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... Batesville
 (STATE OR COUNTRY) Ark.

14. INFORMANT Mrs Annie Mc Kinney
 (Address) 3308 Williams Pl

15. FILED 1929 - 10 - 29 May C Starkloff
 REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 1 19 29
 17. I HEREBY CERTIFY, That I attended deceased from Sept. 27 1929 to October 1 1929 that I last saw him alive on October 1 1929, and that death occurred, on the date stated above, at 8:45 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS: 825
Brain Tumor? Type unknown
Involving region of right cerebrum
Was in City Hospital before being
brought home for his terminal
 CONTRIBUTORY (SECONDARY) Hemiplegia involving left
side of body's head (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? no

WHAT TEST CONFIRMED DIAGNOSIS..... Clinical
 (Signed) Luke B. Emerson M. D.

1012 - 19 29 (Address) 3718 Jennings Rd
 *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 Valhalla Cem. DATE OF BURIAL 10/4 1929

20. UNDERTAKER C.R. Lupton
 ADDRESS 4449

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.

V. S. NO. 2.

