

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

Do not use this space.

14947

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. **791**
Primary Registration District No. **1002**
(No. *City Hospital #2*)

File No.....
Registered No. **4384**
St. Ward)

2. FULL NAME

Frank M. Kinnon

(a) Residence. No. *4156 Dwight* St., *19* Ward.
(Usual place of abode)
Length of residence in city or town where death occurred *about 15* 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 *Male* 4. COLOR OR RACE *Col* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *married*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *8-11-1890*

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day,hrs. ormin.
	<i>39</i>	<i>8</i>	<i>18</i>	

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

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

10. NAME OF FATHER *Isaac McKinnon*

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

12. MAIDEN NAME OF MOTHER *Margaret Baster*

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

14. INFORMANT *A. F. Strudele*
(Address) *City Hosp. #2*

15. FILED *May 4 1930* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *4-29* 19 *30*

17. I HEREBY CERTIFY, That I attended deceased from *11-29*, 19 *29*, to *4-29*, 19 *30*
that I last saw him alive on *4-29*, 19 *30*, and that death occurred, on the date stated above, at *11 1/2* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of Penis
51F 49 (duration) yrs. *18* mos. ds.

CONTRIBUTORY (SECONDARY) *49* (duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? *No* DATE OF.....
WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS? *Biopsy*
(Signed) *H. H. Weathers*, M. D.

4/30, 19 *30* (Address) *City Hosp #2*

*State the DISEASE CAUSING DEATH, or if death was caused by VOLUNTARY OR INVOLUNTARY CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Jefferson Park* DATE OF BURIAL *5-4 1930*

20. UNDERTAKER *Peoples Undertaking Co.* ADDRESS *Franklin*

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.

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

