

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

Do not use this space.

18740

1. PLACE OF DEATH

County Butler

Registration District No. 89

File No.

Township

Primary Registration District No. 3007

Registered No. 96

City Poplar Bluff Mo.

St. Ward)

2. FULL NAME

(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

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

Hubert M. McKinney

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

Sept 30 1904

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

25

8

5

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

Brickmason R.R.

(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)

Grand Tower

10. NAME OF FATHER

J. I. McKinney

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ill.

12. MAIDEN NAME OF MOTHER

Winnie Bridges

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ill.

14.

INFORMANT
(Address)

Hubert M. McKinney
Illmo.

15.

FILED

6/5 30 Dr. B. J. Clark
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

June 5, 1930

17.

I HEREBY CERTIFY, That I attended deceased from June 5-3 P.M., 1930, to June 5-5 P.M., 1930, that I last saw him alive on June 5, 1930, and that death occurred, on the date stated above, at 5:05 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hemorrhage following traumatic amputation of right leg.
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

traumatic amputation - R.R. accident at Malden Mo.
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

✓ DID AN OPERATION PRECEDE DEATH? yes DATE OF June 5-1930

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) W. L. R. M. D.
6/5/30, 19 (Address) Poplar Bluff 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

DATE OF BURIAL

Illmo.

June 6 1930

20. UNDERTAKER

ADDRESS

Clark & Co.

Illmo.

WHITE 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.

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N. B. If information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRAR. ALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

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 Butler
Towship P. Bluff
City P. Bluff (No.)

Registration District No. 89
Primary Registration District No. 2007

File No.
Registered No. 96
St. Ward)

2. FULL NAME

Friedrich Miller 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 m 4. COLOR OR RACE w 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)

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

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 7/5 30 Dr. J. C. Cline REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 5 19 30
17. I HEREBY CERTIFY, That I attended deceased from 19... 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:

Demographic following traumatic amputation of right leg.
CONTRIBUTORY no automobile involved
R.R. accident

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) 243, 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

S-18740