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

Do not use this space.

18173

File No.

Registered No. 2215

1. PLACE OF DEATH
County Jackson Registration District No. 329
Township Main Primary Registration District No. 3962
City Kansas City (No. 411 W. Colorado St. 10 Ward)

2. FULL NAME George Ray McKinney
(a) Residence. No. 411 W. Colorado St., 10 Ward. (If nonresident, give city or town and State)
(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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
W	Wh	Child

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 25-1924

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	6	6	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School
(b) General nature of industry, business, or establishment in which employed (or employer) none
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Kansas City
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER Clyde R. McKinney
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Mo
12. MAIDEN NAME OF MOTHER Ruby Hample
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Mo

14. INFORMANT Clyde R. McKinney
(Address) 411 Colorado

15. FILED 5/22, 1931 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 22 1931

17. I HEREBY CERTIFY, That I attended deceased from May 10, 1931, to May 22, 1931, that I last saw him alive on May 18, 1931, and that death occurred, on the date stated above, at 8:20 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia
105
F&P

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (SECONDARY) Otitis Media

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 105
IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) John K. Lewis, M. D.
May 22 1931 (Address) 3546 Indiana

*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
Mt Moriah	5-25-1931
20. UNDERTAKER' Mrs. C. L. Forster	ADDRESS K.C. Mo.

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

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.

Ok
25-7

Li - 8731

3546 Indiana