

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

Do not use this space.

9742

1. PLACE OF DEATH

County Ray
Township Richmond
City Rayville Mo

Registration District No. 744
Primary Registration District No. 3035

File No. 5976
Registered No. 25
St. _____ Ward)

2. FULL NAME

(a) Residence. No. Rayville Mo 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. 4 mos. 12 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) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 11 - 1932

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
4 12

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None
(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) Ray Co Mo

PARENTS

10. NAME OF FATHER Irene F McKinney

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ray Co Mo

12. MAIDEN NAME OF MOTHER Grace Stapleton

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ray Co

14.

INFORMANT F. F. McKinney
(Address) Rayville Mo

15.

FILED 3-26-33 IS E. E. Day REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 23 1932

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him alive on Mar 22, 1932 and that death occurred, on the date stated above, at 4 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Influenza (Intestinal)
11B (duration) yrs. _____ mos. 4 ds.
CONTRIBUTORY (SECONDARY) 11C (duration) yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS E. E. Day

(Signed) E. E. Day M. D.

, 19____ (Address) Richmond 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

Sanderson Cemetery 3/24 1932

20. UNDERTAKER

ADDRESS

E. E. Day Rayville Mo

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.

THIS IS A PERMANENT RECORD

APR 26 1933

