

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.

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

Do not use this space.

32964

4302

OCT 17 1934

**1. PLACE OF DEATH**

County Jackson  
Township Mau  
City Kansas City (No. 3721 Forest Ave)

Registration District No. 399  
Primary Registration District No. 1002

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Emma F. McKinney

(a) Residence, No. 1507 E 8<sup>th</sup> St., \_\_\_\_\_ Ward.

(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 <u>Fe</u>	4. COLOR OR RACE <u>Wh</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widow</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Alex R. McKinney</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Sept 21 1867</u>		
7. AGE	YEARS <u>66</u>	MONTHS <u>11</u>
	DAYS <u>29</u>	IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>at home</u>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.	
	10. Date deceased last worked at this occupation (month and year) _____	11. Total time (years) spent in this occupation _____
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo Ky</u>		
FATHER	13. NAME <u>Thos J. Tomlison</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo Ky</u>	
	15. MAIDEN NAME <u>Elizabeth J. Tomlison</u>	
MOTHER	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo Ky</u>	
	17. INFORMANT <u>Francis B. McKinney</u> (ADDRESS) <u>3721 Forest</u>	
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Cremated</u> DATE <u>9/21</u> 19 <u>34</u>		
19. UNDERTAKER <u>Mrs. L. Foster</u> (ADDRESS) <u>100 mo</u>		
20. FILED <u>9-22</u> 19 <u>34</u> <u>James Crowe</u> Registrar.		

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 20 1934

22. I HEREBY CERTIFY, That I attended deceased from Sept 16 1934 to Sept 19 1934.  
I last saw her alive on Sept 19 1934. Death is said to have occurred on the date stated above, at 90 m.  
The principal cause of death and related causes of importance were as follows:  
Mites regurgitation complicated with a hemorrhage into the brain  
Date of onset About Sept 14 or 15 1934

Other contributory causes of importance: None

Name of operation None Date of \_\_\_\_\_  
What test confirmed diagnosis? None Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? None Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? None  
(Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place. None

Manner of injury None  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? No  
If so, specify James J. Graham M. D.  
(Signed) \_\_\_\_\_  
(Address) 205 Argyle Bldg

July 2010

J. As. H. Graham  
Argyle Bldg.