

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 ISOLATION HOSPITAL BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1008**City **St Louis Mo.**

(No.....)

St. Ward)

2. FULL NAME **Adeline McKinney.**(a) Residence, No. **916 Brooklyn**St. **16**

Ward.

Length of residence in city or town where death occurred **14** yrs.

mos.

ds.

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

Colored

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

Unknown

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **April 22nd 1894**

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

42**2****14**

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

Factory Worker.

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)

Mississippi.

FATHER MOTHER

13. NAME

Charles Mc Kinney.

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Mississippi

15. MAIDEN NAME

Lillie Baxdal.

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Mississippi.

17. INFORMANT (ADDRESS)

Stella Grady.

18. BURIAL, CREMATION, OR REMOVAL

PLACE **Washington** DATE **7/10** 19**37**

19. UNDERTAKER (ADDRESS)

Reed Sneed

20. FILE NO.

1010

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **7-4**, 19**37**22. I HEREBY CERTIFY, That I attended deceased from **5-13**, 19**37**, to **7-4**, 19**37**.I last saw her alive on **7-4**, 19**37**. Death is said to have occurred on the date stated above, at **9:30 P.**

The principal cause of death and related causes of importance were as follows:

Palmer
Tuberculosis
Intestinal
Tuberculosis

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external cause (violence), fill in also the following: Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?

If so, specify.....

(Signed) *George J. Boylston*(Address) *Isolation Hospital*

