

REC'D NOV 17 1938

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

35754
Do not use this space.

1. PLACE OF DEATH *Greenwood*

(a) County *Greene* Registration District No. *318*

(b) Township *2nd N. Campbell* Primary Registration District No. *15439*

(c) City *Springfield* (d) Street No. *R#* Registered No. *743*

(e) Length of residence in city or town where death occurred yrs. mos. *3* (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *Walter Luciles Mc Kee*

(a) Residence, No. *R#6* St. (If nonresident, give city or town and State)

(Usual place of abode, if no street address, write county or city)

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 *Effie M. Mc Kee*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Jan 14 - 1872*

7. AGE YEARS *66* MONTHS *8* DAYS *22* If LESS than 1 day, ... hrs. or ... min.

OCCUPATION

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

9. Industry or business in which work was done, as law mill, bank, etc. *On farm*

10. Date deceased last worked at this occupation (month and year) *Jan 14 - 1872*

11. Total time (years) spent in this occupation *66*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo. Clay Mc Kee*

FATHER

13. NAME *Clay Mc Kee*

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

MOTHER

15. MAIDEN NAME *Hariett Caplinger*

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

17. INFORMANT *Effie M. Mc Kee* (ADDRESS) *Tenn.*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Oct 6 1938*

22. I HEREBY CERTIFY, That I attended deceased from *1938* to *Oct 6 1938*

I last saw him alive on *Oct 6 1938*. Death is said to have occurred on the date stated above, at *10:30 A.M.*

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

Cerebral Lenz on stage 8 2/3

Other contributory causes of importance: *Vascular hypertension*

Date of onset

Name of operation _____ Date of _____

What test confirmed diagnosis? *Chemical* Was there an autopsy? *No*

23. If death was due to external causes (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? *No*

If so, specify _____

(Signed) *Arthur S. Krapp* M. D. (Address) *450 E. Court St*

18. BURIAL, CREMATION, OR REMOVAL PLACE *First Church Cemetery* DATE *Oct 7 1938*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *W. H. Stryker & Co. Springfield Mo.*

20. FILED *Oct 7 1938* *W. H. Stryker* Local Registrar

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.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, Max Rhodes
#1763, or by Mr. Max Rhodes
Registered Apprentice No. 117, working under my personal supervision.

Signed J. B. Klingner
Licensed Embalmer No. 3358
P. O. Address Springfield, N.H.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.