REC'D JUL 11 1939

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

22120
Do not use this space.

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.

39 36 6

1. PLACE OF DEATH
(a) County: GREENE
(b) Township:
(c) City or: SPRINGFIELD
Registration District No.: 315
Primary Registration District No.: 2001
Registered No.: 475
(d) Street No.: 602 N. Weaver St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 250 Mary Anne McKinney
(a) Residence, No.: 602 N Weaver St.
(Usual place of abode, if no street address, write county or city) (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): Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): 5-25-1863

7. AGE: Years 76 | Months 0 | Days 15 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: House wife
9. Industry or business in which work was done, as 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): Mo 0

FATHER
13. NAME: Jefferson Layton 0
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Mo 0

MOTHER
15. MAIDEN NAME: Mariah Clapp
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Mo

17. INFORMANT (ADDRESS): Thomas McKinney Springfield Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE: Hazelwood DATE: 6-12, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS): W. P. Campbell 868 N. Washington

20. FILED: 6-12-, 1939 Chas A George MD Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): 6/10/, 1939

22. I HEREBY CERTIFY, That I attended deceased from 5/15/, 1939, to 6/10/, 1939
I last saw her alive on 6/10/, 1939. Death is said to have occurred on the date stated above, at 12:45 P m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Hypertensive Heart Disease	7/38
c Decompensation	
131	

Other contributory causes of importance:
Chr Myocarditis
Chr. nephritis
Arterio Sclerosis

Name of operation: Date of:
What test confirmed diagnosis? Was there an autopsy?

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) R. E. Justins, M. D.
(Address) 305½ College St.

(Licensed Embalmer's Statement on Reverse Side)

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, or by.....
K. P. Campbell, Registered Apprentice No.....
working under my personal supervision.

Signed K. P. Campbell

Licensed Embalmer No. 1747

P. O. Address Springfield

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

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