

REC'D AUG 16 1939

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

25134
Do not use this space.

1. PLACE OF DEATH

(a) County Buchanan Registration District No. PD
(b) Township Agency Primary Registration District No. 5-117 Registered No. _____
(c) City _____ (d) Street No. _____ 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 SARAH MCKENNY
(a) Residence, No. Buchanan 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 F 4. COLOR OR RACE w. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan. 3 / 1855

7. AGE YEARS 84 MONTHS 6 DAYS 4 If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House-keeper
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) Kentucky

FATHER 13. NAME James P. Artufur

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

MOTHER 15. MAIDEN NAME Nancy Chas

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

17. INFORMANT (ADDRESS) Lesley Myers Buchanan County Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Plattsburg Mo DATE July 4, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) O'Brien - Ligon Plattsburg Mo

20. FILED July 7, 1939 Lucy Powell Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 7, 1939

22. I HEREBY CERTIFY, That I attended deceased from Dec 1, 1938, to April 1, 1939

I last saw her alive on April 1, 1939. Death is said

to have occurred on the 7th stated above, at 4 A. m.

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

Brain Tumor Date of onset 1935

Other contributory causes of importance:

Diabetes

Name of operation _____ Date of _____

What test confirmed diagnosis? Clinic 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) W L Kenney, M. D.

80 (Address) St Joseph 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.

57

RECEIVED

District Health Officer No. 11;

District File Number 839-1054

Date Filed AUG 11 1939

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, Danell

D. Lyon

or by

Registered Apprentice No. _____, working under my personal supervision.

Signed Danell D. Lyon

Licensed Embalmer No. 3647

P. O. Address Plattsburg, Mo.

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

25131
Do not use this space.

1. PLACE OF DEATH

(a) County Buchanan Registration District No. 80
(b) Township Agency Primary Registration District No. 5117 Registered No.
(c) City (d) Street No.
(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 Sarah Mc Kown

(a) Residence, No. 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
84 6 4

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

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19..

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19..

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-7-39

22. I HEREBY CERTIFY, That I attended deceased from .. to .., 19..

I last saw h. alive on .., 19.. Death is said to have occurred on the date stated above, at .. m.

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

Brain Tumor
Probably malignant
no autopsy but sudden
onset of blindness
with mental symptoms
gradually increasing
diabetes

Date of onset

11/39

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? ..

If so, specify ..

(Signed) H. L. Hennessy, M. D.

(Address) St. Joseph

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
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.

SUPPLEMENT

S-25131 1939