DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 27457

REC'D SEP 14 1939 791

Registration District No. 1008

Primary Registration District No.

Registrar's No. 6957

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

1. PLACE OF DEATH:
(a) County 1
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Since July 7. 1939
(Specify whether)
In this community 22 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 1
(c) City or town St. Louis 22
(If outside city or town limits, write "RURAL")
(d) Street No. 1428 Papin
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

8. (a) PRINT FULL NAME Alfred McKinney 250
8. (b) If veteran, name war No
8. (c) Social Security No. nil
4. Sex M
5. Color or race C
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife unknown
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Feb. 25. 1865 (Month) (Day) (Year)

8. AGE: Years 74 Months 5 Days 10 If less than one day hr. min.

9. Birthplace Alabama (City, town, or county) (State or foreign country)
10. Usual occupation nil 1
11. Industry or business 7
MOTHER FATHER
12. Name Bill McKinney
13. Birthplace unknown (City, town, or county) (State or foreign country)
14. Maiden name Annie Jonas
15. Birthplace unknown (City, town, or county) (State or foreign country)
16. (a) Informant's own signature Maude Wright
(b) Address 1424 Papin St
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/11/39 (Month) (Day) (Year)
(c) Place: burial or cremation E. St. Louis, Ill.
18. (a) Signature of funeral director [illegible]
(b) Address 3517 Saeglede Ave
19. (a) AUG 11 1939 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 5
year 1939 hour 9 minute 25 P.M.
21. I hereby certify that I attended the deceased from July 7. 1939, 19..., to Aug. 5. 1939, 19...;
that I last saw him alive on Aug. 5. 1939, 19...;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Arteriosclerosis with hypertension	8-10 yrs.
Due to: --	
Due to: --	
Other conditions (Include pregnancy within 3 months of death): --	
Major findings: Of operations: --	
Of autopsy: --	

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature H. J. Lyman (M. D. ~~or other~~)
Address 2601 Arsenal Date signed 8/10/39

(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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed .....

Licensed Embalmer No. 1173

P. O. Address 3517 Laclede

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.