

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **27457**
6957
Registrar's No.

DEED SEP 14 1939 **791**

Registration District No. **1008**

Primary Registration District No.

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)

8. (a) PRINT FULL NAME Alfred McKinney 250

3. (b) If veteran, name war no 3. (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 Months Days If less than one day
74 5 20 hr. min.

9. Birthplace Alabama
(City, town, or county) (State or foreign country)

10. Usual occupation nil 1

11. Industry or business 7

12. Name Bill McKinney 7
13. Birthplace unknown ?
(City, town, or county) (State or foreign country)

14. Maiden name Annie Jones
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 (b) Date thereof 8/11/39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation E. St. Louis, Ill.

18. (a) Signature of funeral director R. McKinnon
(b) Address 3517 Sack de Ave

19. (a) AUG 11 1939 (b) J. D. B. B. B.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1
(c) City or town St. Louis
(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.

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
to Aug. 5, 1939, 1939;
that I last saw him alive on Aug. 5, 1939, 1939;
and that death occurred on the date and hour stated above.

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 --

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?

While at work? (Specify type of place) (e) Means of injury

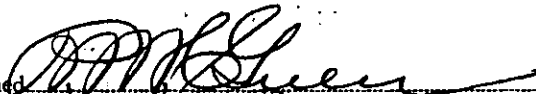
23. Signature H. J. Lyman (M. D. or other)
Address 2601 Chubbuck Date signed 8/10/39

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 Sacke dea

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.