DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 11 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 5520

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 745

1. PLACE OF DEATH:

(a) County: Jackson

(b) City or town: Kansas City, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 3320 Indiana Ave. 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community: 20 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jackson

(c) City or town: Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No.: 3320 Indiana 0
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: Mary M. McKinley 2572

3. (b) If veteran, name war: No

3. (c) Social Security No.: No

4. Sex: F

5. Color or race: W

6. (a) Single, widowed, married, divorced: Widowed

6. (b) Name of husband or wife: McHife James McKinley

6. (c) Age of husband or wife if alive: No years

7. Birth date of deceased: Nov. 1st. 1864 (Month) (Day) (Year)

8. AGE: Years 75 Months 3 Days 17 If less than one day ____ hr. ____ min.

9. Birthplace: Ireland (City, town, or county) 5 (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business: None

MOTHER FATHER

12. Name: Michael Lalley 5

13. Birthplace: Ireland (City, town, or county) (State or foreign country)

14. Maiden name: Nora McLaughlin

15. Birthplace: Ireland (City, town, or county) 5 (State or foreign country)

16. (a) Informant's own signature: Beatrice M. Kinley

(b) Address: 3320 Indiana

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 2/19/40 (Month) (Day) (Year)

(c) Place: burial or cremation: Ft. Smith Arkansas

18. (a) Signature of funeral director: W. H. Mayberry.

(b) Address: 2315 Linwood Blvd.

19. (a) Feb. 19, 1940 (Date received local registrar) (b) M. M. Crane (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Feb. day: 18th. year: 1940 hour: 9:15 minute: A.M.

21. I hereby certify that I attended the deceased from Feb. 12, 1940, to Feb. 18, 1940 that I last saw h. alive on Feb. 18, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Bronchio-pneumonia.	2-17-40
Auricular fibrillation.	2-17-40
Due to: Bronchitis	
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: A. M. Ziegler (M. D.)

Address: 201 Plaza Theatre Bldg. Date signed: 2/19/40

(Licensed Embalmer's Statement on Reverse Side)

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.

MARGIN RESERVED FOR BINDING

Rev. 5-17-39 50M-5-17-39

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.....

P. O. Address.....

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.