. No. 2
-11-10-39
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 22 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 1810

Registration District No. 24-822 Primary Registration District No. 5446 Registrar's No. 11

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County GREENE (b) City or town ~~Springfield~~ Franklin Twp.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Fair Grove R-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 26 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Greene
(c) City or town Fair Grove
(If outside city or town limits, write "RURAL")
(d) Street No. R. R. 2
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME DONNA BERNICE McKINNEY
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased April (Month) 9 (Day) 1940 (Year)
8. AGE: Years Months Days 26 If less than one day hr. min.
9. Birthplace Fair Grove R2 Mo (City, town, or county) (State or foreign country)
10. Usual occupation Child
11. Industry or business
12. FATHER Name William McKinney
13. Birthplace Ky (City, town, or county) (State or foreign country)
14. MOTHER Maiden name Minnie Skelly
15. Birthplace Ky (City, town, or county) (State or foreign country)
16. (a) Informant William McKinney
(b) Address R-2 Fair Grove
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-6-40 (Month) (Day) (Year)
(c) Place: burial or cremation New Hope
18. (a) Signature of funeral director Dunn
(b) Address Springfield Mo
19. (a) (Date received local registrar) (b) Allan Barnes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 5th year 1940 hour 8 minute P.M.
21. I hereby certify that I attended the deceased from 4-11-40 to 5-18-40, 19..; that I last saw h alive on 4-18-40, 19..; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral birth hemorrhage	
Due to: Precipitate Delivery?	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

23. Signature Ruben Bennett (M. D. or other)
Address Springfield Mo Date signed 5-6-40

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

Greene County Health Office,

County File Number 40-6-26

Date Filed 6-10-40

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 wit the above constitutes grounds for revocation of license.)

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