

FILED AUG 14 1940

Registration District No. 399

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 Hrs.
(Specify whether
In this community _____
years, months or days)

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. 2549 Troost Avenue
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME

McKinney infant 250

3. (b) If veteran. name war _____

3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 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 July 30th 1940
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 1 If less than one day hr. 6

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

10. Usual occupation Child

11. Industry or business

MOTHER FATHER { 12. Name Harvey Mc Kinney
13. Birthplace Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Jane Mellon
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Harvey Mc Kinney

(b) Address 2549 Troost Ave.

17. (a) Burial (b) Date thereof 7 31 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenlawn

18. (a) Signature of funeral director Weilert Funeral Home

(b) Address 2332 Monitor Place, K. C. Mo.

19. (a) July 31, 1940 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 30th
year 1940 hour 11 minut 45 A. M.

21. I hereby certify that I attended the deceased from July 30th 1940 to July 30th 1940
that I last saw him alive on July 30th, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death
Prematurity

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy None

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 D. R. Thorne (M. D. or other) _____
Med. Dir. K.C. Gen. Hospital, K.C. Mo.
Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

no. 1007
DATE
CITY
COUNTY
STATE
SEX
AGE
HAIR
EYES
OCCUPATION
RELATIONSHIP TO DECEASED
DATE OF DEATH
PLACE OF DEATH
PLACE OF BURIAL

DECEASED
DATE OF DEATH
PLACE OF DEATH
PLACE OF BURIAL
DATE OF DEATH
PLACE OF DEATH
PLACE OF BURIAL

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. DATE

Signed Blaine E. Wilcox
Licensed Embalmer No. 4075
P. O. Address 2332 Mountain Rd

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.