FILED FEB 17 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 3257

Registration District No. 496 — Primary Registration District No. 3025 — Registrar's No. 1

1. PLACE OF DEATH
(a) County Linn
(b) City or town Brookfield (Inc.) (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 209 S. Clinton St (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 months / In this community (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Linn
(c) City or town Brookfield Mo. (If outside city or town limits, write "RURAL")
(d) Street No. 209 South Clinton (If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME John Harvey McKinney
3. (b) If veteran, name war ____
3. (c) Social Security No. None

4. Sex M
5. Color or race Wh
6. (a) Single, widowed, married, divorced O
6. (b) Name of husband or wife ____
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased Oct (Month) 2 (Day) 1940 (Year)

8. AGE: Years ____ Months 3 Days 4 If less than one day ____ hr. ____ min.

9. Birthplace Brookfield - Mo. (City, town, or county) (State or foreign country)
10. Usual occupation ____
11. Industry or business ____
MOTHER FATHER
12. Name Clarence F. McKinney
13. Birthplace St Louis - Mo (City, town, or county) (State or foreign country)
14. Maiden name Elodie Griffith
15. Birthplace Browning - Mo. (City, town, or county) (State or foreign country)
16. (a) Informant's own signature Mrs. M. Kinney
(b) Address Brookfield, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan-8-1941 (Month) (Day) (Year)
(c) Place: burial or cremation Rose Hill Cemetery Brookfield
18. (a) Signature of funeral director Hill Funeral Chapel
(b) Address Brookfield
19. (a) 1-7-41 (Date received local registrar) (b) Grant Lucas (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 6 year 1941 hour 2 minute 30 A.M.
21. I hereby certify that I attended the deceased from ____, 19__, to ____, 19__; that I last saw h__ alive on Jan. 6, 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pneumonia Lobar	(?)
Due to ____	
Due to (Coroner View)	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations ____
Of autopsy None

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 Dale Bunch (M. D. or coroner)
Address Marceline Mo Date signed 1/6/41

(Licensed Embalmer's Statement on Reverse Side)

X19511

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.

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.