

17-39
X23159

FILED MAR 17 1941

State File No. _____

Registration District No. 426

Primary Registration District No. 4252

Registrar's No. 4

1. PLACE OF DEATH:

(a) County Johnson

(b) City or town Chilhowee
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: in Chilhowee
(If not in hospital or institution, write street number of location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community 9 yrs
years, months or days

3. (a) PRINT FULL NAME George R McGinnis

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 married

6. (b) Name of husband or wife Nellie McGinnis 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Apr 13 1862
(Month) (Day) (Year)

8. AGE: Years 78 Months 7 Days 26 If less than one day _____ hr. _____ min.

9. Birthplace Clay Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation farmer

11. Industry or business _____

12. Name Strawther M. Ginnig

13. Birthplace Unknown Kentucky
(City, town, or county) (State or foreign country)

14. Maiden name Mary Cook

15. Birthplace Unknown Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Nellie McGinnis

(b) Address Chilhowee Mo

17. (a) Burial (b) Date thereof 2 11 41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation West Union

18. (a) Signature of funeral director Fred C. Williams

(b) Address Clinton Mo

19. (a) FEB 11 1941 (b) O. F. Cook
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Henry 51

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

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 9
year 1941 hour 2 minute 20 A.M.

21. I hereby certify that I attended the deceased from _____, 19____, to 2/9, 1941;
that I last saw him alive on 2/9, 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Artery Disease and general atherosclerosis

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 94 W

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

23. Signature M. W. Keedee (M. D. or other) _____
Address Chilhowee Mo Date signed 2/10/41

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

AUG 11 1944

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 3-5-41

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

Fred Wilkerson

Licensed Embalmer No. *2478*

P. O. Address *Clinton*

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 7333

Registration District No. 426

Primary Registration District No. 4252

Registrar's No.

1. PLACE OF DEATH

(a) County Johnson
(b) City or town Chilhowee
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... (Specify whether

In this community.....
years, months or days)

3. (a) PRINT FULL NAME

Geo. R. McGinnis

3. (b) If veteran, name war.....

3. (c) Social Security No.....

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife.....

6. (c) Age of husband, or wife, if alive..... years

7. Birth date of deceased. Apr 13
(Month) (Day) (Year)

1862
(Year)

8. AGE:

Years: 78

Months: 9

Days: 26

If less than one day

hr. min.

9. Birthplace.....

(City, town, or county)

(State or foreign country)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....

(City, town, or county)

(State or foreign country)

14. Maiden name.....

15. Birthplace.....

(City, town, or county)

(State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a) (Burial, cremation, or removal)

(b) Date thereof.....

(Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 4/30-1941
(Date received local registrar)

(b) O. K. Coon
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....

(c) City or town.....
(If outside city or town limits write "RURAL")

(d) Street No.....
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 9
year 1941 hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....;

that I last saw him..... alive on....., 19.....;

and that death occurred on the date and hour stated above.

Immediate cause of death.....

Duration

Due to.....

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?.....

While at work?..... (Specify type of place)

(e) Means of injury.....

23. Signature G. M. Kendall (M. D. or other) 1

Address Chilhowee Mo Date signed.....

SUPPLEMENTAL COPY

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

