DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 14 1942

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29639

Registration District No. 1 | Primary Registration District No. 3000 | Registrar's No. 231

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

1. PLACE OF DEATH:
(a) County Adair
(b) City or town Kirksville Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 616 N Osborn
(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 2 weeks

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Atchison 3
(c) City or town Rockport (If outside city or town limits, write "RURAL.") 6
(d) Street No. City (If rural, give location)
(e) Citizen of foreign country? (Yes or No) /
If yes, name country

3. (a) PRINT FULL NAME James Elmer McKinney
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 Lula Mae McKinney | 6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased March (Month) 11 (Day) 1880 (Year)

8. AGE: Years 62 | Months 5 | Days 27 | If less than one day ... hr. ... min.

9. Birthplace Newton Iowa (City, town, or county) / (State or foreign country)

10. Usual occupation Ice Cream Dealer

11. Industry or business —

MOTHER FATHER
12. Name Unknown
13. Birthplace Iowa (City, town, or county) / (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

16. (a) Informant Mrs. Lula Mae McKinney
(b) Address Rock Port — Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 11 1942 (Month) (Day) (Year)
(c) Place: burial or cremation Rockport Mo.

18. (a) Signature of funeral director Sears Funeral Home
(b) Address Kirksville Mo

19. (a) Sept 9 1942 (Date received local registrar) Mrs. J. P. Wagner (Registrar's signature)

10 [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 8th
year 1942 hour 10 minute 40 A.M.

21. I hereby certify that I attended the deceased from August 24th, 1942, to Sept 8th, 1942, that I last saw him alive on Sept 8 A.M., 1942, and that death occurred on the date and hour stated above.

Immediate cause of death Fatal Hemorrhage from erosion of external Carotid artery

Due to Previous surgery of large tumor of neck

Due to —

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

Duration

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 2

23. Signature Dallas L. Gordon Jr. (M.D. or other) M.D.
Address Kirksville, Mo Date signed 9-9-42

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 10-42-2888
Date Filed OCT 12 1942

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 Keith Collier

Licensed Embalmer No. 3632

P. O. Address Tuskegee Ala

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

s No. 2B
—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 29639

Registration District No. 1 — Primary Registration District No. 3000 — Registrar's No. 235

1. PLACE OF DEATH:

(a) County: Adair
(b) City or town: Kirksville
(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)

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) Citizen of foreign country? (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: James E. McKinney
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: Mar (Month) 11 (Day) 1880 (Year)

8. AGE: Years: 62 Months: 5 Days: 2 If less than one day: hr. min.

9. Birthplace: (City, town, or county) Iowa (State or foreign country)
10. Usual occupation:
11. Industry or business:

FATHER
12. Name:
13. Birthplace: (City, town, or county) (State or foreign country)

MOTHER
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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Sept. day:
year: 1942 hour: minute: M.

21. I hereby certify that I attended the deceased from ..., 19..., to ..., 19...; that I last saw h... alive on ..., 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Fatal Hemorrhage from Ligation of Internal Carotid about	
Due to: Peripheral surgery of large tumor of Neck	
Due to: tumor reported by our Pathologist as Medullo Sarcoma	
Other conditions (Include pregnancy within 3 months of death):	

Major findings:
Of operations: 44
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: Hallie C. Gordon Jr. (M.D. or other) MD
Address: Kirksville, Mo. Date signed:

SUPPLEMENTARY