

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.

FILED JUL 7 1943

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

22033

Do not use this space.

1. PLACE OF DEATH

(a) County Monroe Registration District No. 227
 (b) Township Jefferson Primary Registration District No. 5-804 Registered No. 6187
 (c) Infirmary (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

ERNES S. McKINNEY
 (a) Residence, No. Madison mo. St. Mo. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single
 6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ✓
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 2/17-1874
 7. AGE YEARS 69 MONTHS 4 DAYS 6 If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc. Farmer
 10. Date deceased last worked at this occupation (month and year) 3 years 11. Total time (years) spent in this occupation life

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Monroe Co Mo

13. NAME Ernest S. McKinney

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

15. MAIDEN NAME Martha V Ray

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

17. INFORMANT Joe A. McKinney (ADDRESS) Madison mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Madison mo DATE 6/4 1943

19. FUNERAL DIRECTOR (NAME) (ADDRESS) First A. Thompson Madison mo

20. FILED 7-2 1943 Kathryn Pascoe Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-2 1943

22. I HEREBY CERTIFY, That I attended deceased from May 20 1942 to June 2 1943

I last saw him alive on June 2 1943 Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Cerebral Embolism Date of onset 5/24/43

Other contributory causes of importance: 83 f

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) W. H. P. P. P., M. D.

(Address) _____

RECEIVED

District Health Officer No. 10

District File Number 7-43-1143

Date Filed JUL 6 1943

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. 1478

P. O. Address Modena, Mo.

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.