No. 2
-2-43
-17-39
X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN
FILED FEB 29 1944

Registration District No. 3960

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6069

State File No. 4140

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Clair

(b) City or town Osceola Rural (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) 30 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Clair

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

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

(e) Citizen of foreign country? No (Yes or No)

If yes, name country /

3. (a) PRINT FULL NAME Ellis E. Mckinney

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

3. (c) Social Security No No

4. Sex Male

5. Color or race White

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

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

6. (c) Age of husband or wife if alive 33 years

7. Birth date of deceased 9- (Month) 12- (Day) 1877 (Year)

8. AGE: Years 66 | Months 3 | Days 27 | If less than one day ____ hr. ____ min.

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

10. Usual occupation Mechanic

11. Industry or business

MOTHER FATHER

12. Name George McKinney

13. Birthplace Calloway County (City, town, or county) Missouri (State or foreign country)

14. Maiden name Minnie Penning

15. Birthplace St. Albury (City, town, or county) Mo. (State or foreign country)

16. (a) Informant Edith McKinney

(b) Address Osceola Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-11-44 (Month) (Day) (Year)

(c) Place: burial or cremation Osceola Cemetery

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

(b) Address Osceola Missouri

19. (a) 1-10-1944 (Date received local registrar) (b) [signature] (Registrar's signature)

1100 (Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January 8 December year 1944 hour 8 minute 30 P.M.

21. I hereby certify that I attended the deceased from 12-30-43 19 to Jan 8 19 44 that I last saw him alive on Jan 8 19 44 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pneumonia atypical	8
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Ruth Sellers (M. D.)

Address Osceola Mo Date signed 1-10-44

DEC 4 1944

JAN 2 1945

RECEIVED
District Health Officer No. 7,
District File Number 1-44-1
Date Filed 1-28-44

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 Paul Firestone

Licensed Embalmer No. 3990

P. O. Address Oscoola mo

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

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

. No. 2B
M—5-43
P I X36930

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Feb

Registration District No. 314 Primary Registration District No. 6064 Registrar's No.

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

1. PLACE OF DEATH:
(a) County St Clair
(b) City or town Osceola Twp. Rural
(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 years, months or days)
In this community

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 Elsie 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 Sept 12 (Month) (Day) 18 (Year)

8. AGE: Years 66 Months 3 Days If less than one day hr. min.

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

MOTHER / 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)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 14 year 1944 hour P.M. 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 Pneumonia	
Bronchial	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations 107	
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 Ruth Sievers (M. D. [illegible]) Address Date signed 2-6-44

4140