

FILED MAR 9 1944

State File No. _____

Registration District No. 314

Primary Registration District No. 4459

Registrar's No. _____

1. PLACE OF DEATH:
(a) County St. Clair
(b) City or town Osceola
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community all of life years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Clair
(c) City or town Osceola
(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 Alice May McKinley
3. (b) If veteran, name war _____ 3. (c) Social Security No. No

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan day 19 year 1944 hour 4 minute 15 P. M.

4. Sex F s/Color or race _____
6. (a) Single, widowed, married, divorced, widowed
6. (b) Name of husband or wife James William McKinley 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: Mar 17 1862 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 1-2 1944, to 1-19 1944 that I last saw her alive on 1-19 1944 and that death occurred on the date and hour stated above.
Immediate cause of death: Influenza Duration 1-2-44

8. AGE: Years 81 Months 10 Days 2 If less than one day _____ hr. _____ min.

Due to _____
Due to _____
Other conditions Senility (Include pregnancy within 3 months of death)

9. Birthplace Van Buren Co. Iowa (City, town, or county) (State or foreign country)

Major findings: Of operations _____ Of autopsy _____
PHYSICIAN ZZA
Underline the cause to which death should be charged statistically.

11. Industry or business _____
12. Name Unknown
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace _____ (City, town, or county) (State or foreign country)

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? _____

16. (a) Informant Mrs. Percy Buchanan
(b) Address Osceola, Mo.
17. (a) Burial (b) Date thereof 1-21-44 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Osceola
18. (a) Signature of funeral director Osceola Funeral Home
(b) Address Osceola, Mo.
19. (a) 2/19/44 (b) Phendrick (Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place) (c) Means of injury _____
23. Signature Paul Seivers (M. D. or other) _____
Address Osceola, Mo. Date signed 1-20-44

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

1100

RECEIVED

District Health Officer No. 7.

District File Number 2-44-296

Date 3-8-44

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 J. Tristone

Licensed Embalmer No. 3990

P. O. Address Ossola 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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. March
Registrar's No. _____

Registration District No. 314 Primary Registration District No. 4459

1. PLACE OF DEATH:

(a) County St Clair
(b) City or town Osceola
(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 Life years, months or days

3. (a) PRINT FULL NAME

Abigail May McKenley

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F 5. Color or race White 6. (a) Single, widowed, married, divorced w

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year

7. Birth date of deceased mar 17 1876
(Month) (Day) (Year)

8. AGE: Years 81 Months 10 Days _____ (If less than one day, _____ min.)

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

10. Usual occupation Housekeeper

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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) J. B. Bland
(Data received local registrar) (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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan 1944 year. (a) _____ (b) _____ minute. M.

21. I hereby certify that I attended the deceased from _____ 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 _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

8146