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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 30 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19988
1880
State File No.
Registrar's No. 5581

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:
(a) County.....
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Missouri Baptist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community 0 years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County.....
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 5168 Cates Ave.
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Charles A. McKinnon
3. (b) If veteran, name war..... 3. (c) Social Security No.....

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month June day 19
year 1944 hour..... minute 6:30 P.M.

4. Sex Male 5. Color or race Wh. 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Ella McKinnon 6. (c) Age of husband or wife if alive 65 years
7. Birth date of deceased August 15 1878
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 6-2 1944 to 6-19 1944
that I last saw him alive on 6-19 and that death occurred on the date and hour stated above.

8. AGE: Years 65 Months 10 Days 4 If less than one day hr. min.

Immediate cause of death Cancer of bowels
Duration
Due to.....
Due to.....
Other conditions (Include pregnancy within 3 months of death)
Major findings: By husband C.A. of Cincin and
Of autopsy bowels

9. Birthplace Potosi Mo.
(City, town, or county) (State or foreign country)
10. Usual occupation Retired

11. Industry or business Cleaning Business
12. Name Theophilus McKinnon
13. Birthplace Caledonia Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Julia Agnes Effinger
15. Birthplace Potosi, Mo.
(City, town, or county) (State or foreign country)

PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Ella McKinnon
(b) Address 5168 Cates Ave.
17. (a) Burial (b) Date thereof 6-21-1944
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Olive Cemetery

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?.....

18. (a) Signature of funeral director Herman Reindorf
(b) Address 5216 Delmar Blvd.
19. (a) JUN 20 1944 (b) J. A. Bredek
(Date received local registrar) (Registrar's signature)

While at work?..... (Specify type of place) (c) Means of injury 0
23. Signature J. H. Taylor M.D. (M. D. or other)
Address 75-369 Taylor Date signed 6-20-44

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

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 *John Ketter*.....

Licensed Embalmer No. *3880*.....

P. O. Address *4355 Washington*.....

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.