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 JUN 22 1944

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

F 21047

Do not use this space.

1. PLACE OF DEATH
(a) County Boone Co. Registration District No. 40
(b) Township Rocky Fork 10 Primary Registration District No. 5122 Registered No.
or
(c) City Near Hallsville (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 Delilda McKinzie
(a) Residence, No. Country St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF James W. McKinzie
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 9 1863
7. AGE Years 80 Months 10 Days 25 If LESS than 1 day, ...hrs. or ....min.

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

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

FATHER
13. NAME Jacob Palm
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Penn.

MOTHER
15. MAIDEN NAME Lucinda Alspaw
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mercer Co. Ohio

17. INFORMANT (ADDRESS) J. P. McKinzie 302 Melbourne St. Columbia

18. BURIAL, CREMATION, OR REMOVAL
PLACE Red Top Cemetery DATE June 6 1944

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Parker Funeral Service Columbia Mo.

20. FILED June 6 1944 Mrs Ralph Bryan
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 4, 1944

22. I HEREBY CERTIFY, That I attended deceased from 1936, 19..., to May 31, 1944
I last saw her alive on May 31, 1944. 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:

	Date of onset
Carcinoma of eye	

Other contributory causes of importance: Senility 55c

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) [signature], M. D.
(Address) Ventralia Mo.

(Licensed Embalmer's Statement on Reverse Side)

JUN 22 1944

RECEIVED
District Health Officer No. 9,

District File Number.....

Date Filed 6-21-44

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 Chas Baring

Licensed Embalmer No. 4132

P. O. Address Columbia

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

If this body is not embalmed, above space should be left blank.