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M-8-43
2-5-17-39
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24846

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 171

FILED JUL 20 1944

Registration District No. 146

Primary Registration District No. 5568

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Rural Blue
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: RFD #1 Independence, Courtney-Atherton
(If not in hospital or institution, write street number or location) Rd.
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 25 Years
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson 48
(c) City or town Rural Blue 0
(If outside city or town limits, write "RURAL")
(d) Street No. RFD #1 Independence.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____ 1)

3. (a) PRINT FULL NAME OLIVE ALENE MC KINNEY

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

6. (b) Name of husband or wife H.B. McKinney 6. (c) Age of husband or wife if alive 51 years

7. Birth date of deceased January 8th, 1891
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>53</u>	<u>5</u>	<u>9</u>	hr. _____ min. _____

9. Birthplace Lake Geneva, Wisconsin
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Roswell Wilcox

13. Birthplace No Data 9
(City, town, or county) (State or foreign country)

14. Maiden name Catherine Andes

15. Birthplace No Data 9
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. H. B. McKinney

(b) Address RFD. #1 Independence, Mo.

17. (a) Burial (b) Date thereof 6/20/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Meund Grove Cemetery

18. (a) Signature of funeral director Coland B. Speaks

(b) Address Independence Missouri

19. (a) 6-19-1944 (Date received local registrar) (b) James Ross (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 17th,
year 1944 hour 1 minute P. M.

21. I hereby certify that I attended the deceased from December 17, 1941 to June 17, 1944
that I last saw her alive on June 13, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of the cervix of uterus Duration 3 yrs

Dug to Patient treated by Dr. J. J. ... of Columbia Mo

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy HSA

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 plane) _____
While at work? _____ (Specify type of injury) _____

23. Signature James Ross (M. D. or other) _____
Address Independence Mo Date signed 6-19-44

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

78000

JUL 25 1944

NOV 27 1958

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 *Coland P. Speakes*.....

Licensed Embalmer No. *3604*.....

P. O. Address *Indip. 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.