S. No. 2
0M—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 23 1945

Registration District No. 199

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 12383

Primary Registration District No. 1002

Registrar's No. 1671

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town K. C. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: K. C. Tuberculosis Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 mo. 14 days (Specify whether years, months or days) In this community 2 days

2. USUAL RESIDENCE OF DECEASED: 48 9 6

(a) State Mo (b) County Jackson

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

(d) Street No. 1616 Michigan (If rural, give location)

(e) Citizen of foreign country? No 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Edward McKinney

3. (b) If veteran, name war NONE

3. (c) Social Security No. DON'T KNOW

4. Sex M 9

5. Color or race negro

6. (a) ~~Single~~, ~~widowed~~, married, divorced married 1

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

6. (c) Age of husband or wife if alive 43 years

7. Birth date of deceased April (Month) 19 (Day) 1900 (Year)

8. AGE: Years 44 | Months 11 | Days 23 | If less than one day hr. min.

9. Birthplace (City, town, or county) Miss. (State or foreign country) 1

10. Usual occupation Laborer

11. Industry or business

MOTHER FATHER

12. Name Ross McKinney

13. Birthplace (City, town, or county) Miss. (State or foreign country) 1

14. Maiden name DON'T KNOW

15. Birthplace (City, town, or county) Miss. (State or foreign country) 1

16. (a) Informant Elsie McKinney

(b) Address 1616 Michigan

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-14-45 (Month) (Day) (Year)

(c) Place: burial or cremation Highland

18. (a) Signature of funeral director Elmer Greendyke

(b) Address 1819 E. 15th K C Mo

19. (a) 4-13-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month April day 12 year 45 hour 3 minute 55 M.

21. I hereby certify that I attended the deceased from 1-2 19 45 to 4-12 19 45 that I last saw him alive on 4-11 19 45 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pulmonary T.B.	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations 13	
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 Daniel W. King (M. D. or other)

Address K. C. T.B. Hospital Date signed 4-12-45

(Licensed Embalmer's Statement on Reverse Side)

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 W. E. Glynn

Licensed Embalmer No. 4383

P. O. Address 1819 E. 15th Kan

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.