

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17663

FILED MAY 16 1945

Registration District No. 245

Primary Registration District No. 3047

Registrar's No. 43

1. PLACE OF DEATH:

(a) County Newton
(b) City or town Newton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Memorial Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 30 Minutes
(Specify whether
In this community All his life
years, months or days)

3. (a) PRINT FULL NAME

Frankie Lee McKinney

3. (b) If veteran,

name war.

3. (c) Social Security

No.

4. Sex Male

5. Color or

race

6. (a) Single, widowed, married,

divorced

6. (b) Name of husband or wife

6. (c) Age of husband or wife if

alive years

7. Birth date of deceased September 12 1943
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

1

7

7

hr. min.

9. Birthplace

Ottawa County

Oklahoma

(City, town, or county)

(State or foreign country)

10. Usual occupation

HOUSE WIFE

11. Industry or business

MOTHER FATHER

12. Name

Warren McKinney

13. Birthplace

Marshall

Arkansas

(City, town, or county)

(State or foreign country)

14. Maiden name

Versie Nora Hillhouse

15. Birthplace

Oklahoma

Arkansas

(City, town, or county)

(State or foreign country)

16. (a) Informant

Warren McKinney

(b) Address

Wyandotte Oklahoma

17. (a)

Burial

(b) Date thereof

April 20 1945

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation

Seneca, Mo.

18. (a) Signature of funeral director

B.W. Buzzard

(b) Address

Seneca, Missouri

19. (a)

4-24-1945

(b)

Corley Thompson

(Date received local registrar)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Oklahoma (b) County Ottawa
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Wyandotte R.F.D. #1
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 19
year 1945 hour 7 minute 30 P.M.

21. I hereby certify that I attended the deceased from
Apr. 19, 1945 to Apr. 19, 1945
that I last saw him alive on Apr. 19
and that death occurred on the date and hour stated above.

Immediate cause of death accidental -
Burned to death

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

22. If death was due to external causes, specify following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur?

(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 Dr. J. W. Buzzard (M. D. or other)

Address Seneca Mo Date signed 4-21-45

(Licensed Embalmer's Statement on Reverse Side)

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

Not embalmed.

Registered Apprentice No.

working under my personal supervision.

RECEIVED MAY 14 1945

District Health Officer No.

District File Number *445-73*

Date Filed *MAY 14 1945*

Signed

Bill Buffard

Licensed Embalmer No.

2334

P. O. Address

Seneca 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. June
Registrar's No. 42Registration District No. 245Primary Registration District No. 3047

1. PLACE OF DEATH:

(a) County Newton
(b) City or town NEOSHO
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
SALE MEMORIAL HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____
years, months or days)

3. (a) PRINT
FULL NAMEFrankie L. McKinnon

3. (b) If veteran,

name war _____

3. (c) Social Security

No. _____

4. Sex M5. Color or
race (W)6. (a) Single, widowed, married,
divorced 5

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if
alive _____ years7. Birth date of deceased Sept 12 1945

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace _____

(City, town, or county)

(State or foreign country)

10. Usual occupation _____

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) _____

(Date 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 April 9
year 1945 hour _____ minute _____ M.21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____Due to Burned by
starting fire in car
stable which was
or gasoline) exploded
building mother's
her two children,Other conditions _____
(Include pregnancy within 3 months of death)
SUPPLEMENTARY
INFORMATION
REQUESTEDMajor findings:
Of operations _____
Of autopsy _____22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) accident
(b) Date of occurrence April 9 - 45
(c) Where did injury occur? Attano Co. aka
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
at home - residence.
(Specify type of place)
While at work? _____ (e) Means of injury _____23. Signature J. B. Sumner (M. D. or other)
Address Seneca Mo Date signed _____

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

17663