. S. No. 2
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ev. 5-17-39
b I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 26516

FILED SEP 1 1945

Registration District No. 49 Primary Registration District No. 1002 Registrar's No. 3457

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days (Specify whether years, months or days)
In this community 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 4032 Raytown Road
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Charles McKinney
3. (b) If veteran, name war No
3. (c) Social Security No. None
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Pearl McKinney
6. (c) Age of husband or wife if alive 55 years
7. Birth date of deceased Feb. (Month) 19th, (Day) 1873 (Year)

8. AGE: Years	Months	Days	If less than one day
72	5	27	hr. min.

9. Birthplace (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Gardner
11. Industry or business Green House
FATHER
12. Name Charles Mc Kinney
13. Birthplace (City, town, or county) Missouri (State or foreign country)
MOTHER
14. Maiden name Harriet Hope
15. Birthplace (City, town, or county) Missouri (State or foreign country)
16. (a) Informant Mrs. Pearl McKinney
(b) Address 4032 Raytown Rd.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/18/45 (Month) (Day) (Year)
(c) Place: burial or cremation Greenlawn Cem.
18. (a) Signature of funeral director Earp Funeral Home
(b) Address 4139 East 15th. St.
19. (a) 8-17-45 (Date received local registrar) (b) Geraldine Hemes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 16 year 1945 hour 2 minute 40 A.M.
21. I hereby certify that I attended the deceased from Augsut 15 19 45, to August 16 19 45; that I last saw him alive on August 16 19 45; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
bronchopneumonia	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) 107	
Major findings: Of operations	
Of autopsy see above	

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 Clark W. Seeley M.D. (M. D. or other)
Address Med. Dir. K.C. General Hospital Date signed

(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 John B. Carp

Licensed Embalmer No. 2955

P. O. Address Y. C. 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.