

No. 2  
-8-13  
-17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

34424

**FILED** **OCT 24 1945** **STANDARD CERTIFICATE OF DEATH**

State File No. \_\_\_\_\_

Registration District No. 290

Primary Registration District No. 5983

Registrar's No. 95

**1. PLACE OF DEATH:**

(a) County Pulaski  
(b) City or town Waynesville - Mo Rural  
(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location) 3  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community 25 yrs. years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Pulaski 85  
(c) City or town Waynesville Rural 0  
(If outside city or town limits, write "RURAL")  
(d) Street No. Route # 2 0  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Oct. day 13  
year 1945 hour 7:30 minute P M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, 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 Broken Neck Duration \_\_\_\_\_

Due to Struck by Log Pole on Rt. S. 66. 1 mile East of Waynesville

Other conditions (Include pregnancy within 3 months) Inquest 700

Major findings: Of operations Pending 71 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) Accident 85  
(b) Date of occurrence 10/13/45 7:30 pm  
(c) Where did injury occur? Waynesville Pulaski Mo (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? on Rt. S. 66 1 mile East Waynesville (Specify type of place)  
While at work? \_\_\_\_\_ (e) Means of injury Broken Neck

23. Signature R. B. Jumper, Coroner Address Richland Mo Date signed 10/14/45

3. (a) PRINT FULL NAME Louie Rockford McKinnon

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

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

6. (b) Name of husband or wife Irene McKinnon 6. (c) Age of husband or wife if alive 33 years

7. Birth date of deceased June 24 1906 (Month) (Day) (Year)

8. AGE: Years 39 Months 3 Days 27 If less than one day hr. \_\_\_\_\_ min. 0

9. Birthplace Phelps Co. Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business \_\_\_\_\_

12. Name Henry McKinnon

13. Birthplace Pulaski Co. Mo (City, town, or county) (State or foreign country)

14. Maiden name Elia Clark

15. Birthplace Don't Know (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Irene McKinnon

(b) Address Waynesville, Mo. R #2

17. (a) Burial (b) Date thereof 10-16-45 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Antioch Cemetery

18. (a) Signature of funeral director J. L. Hoops & Sons

(b) Address Crocker, Mo.

19. (a) 10-20-1945 (b) Chas. M. Oadt (Date received local registrar) (Registrar's signature)

1170

(Licensed Embalmer's Statement on Reverse Side)

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

FEB 8 1950

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

*Paul B. Hoop*

Licensed Embalmer No. *3261*

P. O. Address *Crocker, 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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Nov  
Registrar's No. 95

Registration District No. 290

Primary Registration District No. 5983

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

1. PLACE OF DEATH

(a) County Platte  
(b) City or town Rural Waynesville  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether years, months or days)

3. (a) PRINT FULL NAME Louis R McKinnon

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

4. Sex m 5. Color or race w 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 June 2 1902  
(Month) (Day) (Year)

8. AGE: Years 39 Months 3 Days 0 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
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) (Burial, cremation, or removal) \_\_\_\_\_ (b) Date thereof (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 Nov Day 9 Year 1945 Hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_, that I last saw him \_\_\_\_\_ and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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? \_\_\_\_\_  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other)  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

34424