No. 2
8-43
6-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

34450

FILED OCT 29 1945

State File No.

Registration District No. 30 1

Primary Registration District No. 6035

Registrar's No. 2057

1. PLACE OF DEATH:
(a) County Ripley
(b) ~~City~~ or town Jordan Twp.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: at home (Rural)
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether)
In this community 52 years
years, months or days)

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

3. (a) PRINT FULL NAME John Mc. Kinney
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 Nancy J. Sharp
6. (c) Age of husband or wife if alive 72 years
7. Birth date of deceased 11 (Month) 18 (Day) 1865 (Year)

8. AGE: Years 79 | Months 10 | Days 1 | If less than one day hr. min.

9. Birthplace Carter Co. (City, town, or county) Missouri (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name James K. Mc. Kinney
13. Birthplace Tennessee (City, town, or county) (State or foreign country)
14. Maiden name Martha Clark
15. Birthplace Tennessee (City, town, or county) (State or foreign country)
16. (a) Informant Nancy J. Mc. Kinney
(b) Address Doniphan Mo., R-2
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-21-45 (Month) (Day) (Year)
(c) Place: burial or cremation Macedonia
18. (a) Signature of funeral director E. L. Jordan
(b) Address Doniphan Mo.
19. (a) 10-15-45 (Date received local registrar) (b) E B Johnston (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. 1 day 19
year 1945, hour 4, minute 40 P. M.
21. I hereby certify that I attended the deceased from ..., 19..., to ..., 19...;
that I last saw h... alive on Sept - 14 - 1945
and that death occurred on the date and hour stated above.

Duration

Immediate cause of death Coban Pneumonia 1 week
Due to
Due to
Other conditions. (Include pregnancy within 3 months of death)
Major findings:
Of operations 108
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 [illegible] (M. D. or other) M.D.
Address Doniphan Mo. Date signed

674

(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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed .....

Licensed Embalmer No.....

P. O. Address.....

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.

. No. 2B
M—3-45
I X43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. A-077

Registration District No. 201 Primary Registration District No. 6035 Registrar's No. 2057

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

1. PLACE OF DEATH:

(a) County Ripley

(b) City or town Rural Jordan Twp
(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)

In this community

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

3. (a) PRINT FULL NAME John McKinney

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 M

6. (b) Name of husband or wife

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

7. Birth date of deceased Nov (Month) 18 (Day) [illegible] (Year)

8. AGE: Years 79 Months Days If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov Day 19
year 1941 hour minute M.

21. I hereby certify that I attended the deceased from [illegible], 19..., to [illegible], 19...; that I last saw h... alive on [illegible], 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
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 (M. D. or other)

Address Date signed

SUPPLEMENTARY

34450