V. S. No. 2
0M—9-4-41
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

FILED DEC 7 1945

State File No. 36663

Registration District No. 42 — Primary Registration District No. 1000 — Registrar's No. 1241

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

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital #2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 yrs 11 mos 14 da (Specify whether years, months or days)
In this community 6 yrs 11 mo. 14 da.

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 1426 Charlotte St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Goldie B. McKinney
3. (b) If veteran, name war Nil
3. (c) Social Security No. Nil
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Norgueen
6. (c) Age of husband or wife if alive Deceased years
7. Birth date of deceased Mar (Month) 13 (Day) 1889 (Year)

8. AGE: Years 56 | Months 8 | Days 3 | If less than one day ____ hr. ____ min.

9. Birthplace Milan (City, town, or county) Mo (State or foreign country)
10. Usual occupation None
11. Industry or business
FATHER 12. Name Marion T McKinney
13. Birthplace (City, town, or county) Mo (State or foreign country)
MOTHER 14. Maiden name Sarah E Compton
15. Birthplace (City, town, or county) Mo (State or foreign country)
16. (a) Informant Mrs Stella Woods
(b) Address 1426 Charlotte Kansas City Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-19-45 (Month) (Day) (Year)
(c) Place: burial or cremation Green Lawn KC Mo
18. (a) Signature of funeral director Fleeman & Son Inc
(b) Address St Joseph Mo.
19. (a) Nov 23-45 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11/16 day ____ year 1945 hour 3 minute 35 P.M.
21. I hereby certify that I attended the deceased from 11/9, 1945 to 11/16, 1945 that I last saw her alive on 11/16, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic Myocarditis	Few yrs
Due to Paresis	8 yrs +
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 [signature] (M. D. or other)
Address State Hospital #2 Date signed 11/16 1945

1428 (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 Robert L Gaple

Licensed Embalmer No. 3308

P. O. Address St Joseph, 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.