

No. 2
-5-43
5-17-39
I X36677

FILED MAR 18 1946

Registration District No. 160

Primary Registration District No. 30305592

Registrar's No. 140

1. PLACE OF DEATH:

(a) County Jefferson

(b) City or town Festus, Mo. R. # 1
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 12 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jefferson 50

(c) City or town Festus, R. F. D # 1
(If outside city or town limits, write "RURAL") 0

(d) Street No. _____ (If rural, give location) 0

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME John E. McKee

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 Anna McKee Nee Brown

6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased Feb., 15, 1868
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>78</u>	<u>0</u>	<u>21</u>	hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business Dairy Farmer

12. Name Seth McKee

13. Birthplace Ware, Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Dewey McKee

(b) Address Festus, Mo., R. # 1

17. (a) Burial (b) Date thereof 3/8/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Roselawn, Festus Mo

18. (a) Signature of funeral director H. H. [unclear]

(b) Address Festus, Mo.

19. (a) March 1946 (b) Clara Brown
(Date received local registrar) (Registrar's signature)

142 (Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 6, year 1946 hour 4:30 minute A M.

21. I hereby certify that I attended the deceased from Feb 26-46 to March 6 - 1946

that I last saw him alive on March 6 - 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Traumatic Pneumonia

Due to Fall from wagon

Due to Emphysema

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: _____

Of operations _____

Of autopsy _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 J. J. [unclear] (M. D. or other) _____

Address Crystal City Mo Date signed 3/7/46

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

MOTHER FATHER

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. April 1946
Registrar's No. 14

Registration District No. 160 Primary Registration District No. 5592

1. PLACE OF DEATH:

(a) County Jefferson
(b) City or town Rural
(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 _____)
In this community _____ years, months or days

3. (a) PRINT FULL NAME

John E. McKee

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 _____ years

7. Birth date of deceased Feb 15 (Month) (Day) (Year)

8. AGE: Years 78 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

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) _____ (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 MO (b) County Jefferson
(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 Feb Day 26 Year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Feb 26/46 to March 6, 1946 that I last saw him alive on March 6, 1946 and that death occurred on the date and hour stated above in immediate case of death traumatic pneumonia

Duration _____

Due to Fall from wagon

Due to Terminal Pneumonia

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy 7860-5

22. If death was due to external causes, fill in the following:

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

(b) Date of occurrence Feb 26/46

(c) Where did injury occur? _____ (City or town) (County) (State) on farm

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work Yes (Specify type of place) (e) Means of injury Fall from wagon

23. Signature J. H. Russell (M. D. or other) _____

Address Crystal City Date signed March 11/46

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN Underline the cause to which death should be charged statistically.

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

8816

9892