

No. 2
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17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 24 1946
THE STATE BOARD OF HEALTH, OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40243

State File No. _____

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 970

1. PLACE OF DEATH:
 (a) County GREENE
 (b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Burge Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 20 Days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County Greene 39
 (c) City or town Springfield
(If outside city or town limits, write "RURAL")
 (d) Street No. 1501 W. Olive
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME John D. McKinney
 3. (b) If veteran, name war None
 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month 12 day 2
 year 1946 hour 11 minute 10 A.M.
 21. I hereby certify that I attended the deceased from 11-15
 _____, 1946, to Present time
 that I last saw him alive on 12-2, 1946
 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race white
 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife Mary J. McKinney
 6. (c) Age of husband or wife if alive ✓ years
 7. Birth date of deceased July 9 1864
(Month) (Day) (Year)

Immediate cause of death
Pulmonary Embolism 30 min
Due to Thrombosis, left femoral 1 day?
Due to vein
Fracture Rt. Hip 3 wks
 Other conditions _____
(Include pregnancy within 3 months of death)

8. AGE: Years 82 Months 4 Days 23
 If less than one day _____ hr. _____ min.

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

10. Usual occupation Worker in Mattress Factory
 11. Industry or business Factory Workers

12. Name James J. McKinney

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

14. Maiden name Sarah

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

16. (a) Informant Lloyd J. McKinney
 (b) Address 1508 W. Lee Springfield Mo.

17. (a) Burial (b) Date thereof Dec 4 - 1946
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Green Lawn Cem.

18. (a) Signature of funeral director J. W. Klingner & Co.
 (b) Address Springfield Mo.

19. (a) 11-4-46 (b) W. R. Handley MD.
(Date received local registrar) (Registrar's signature)

Major findings: _____
 Of operations _____
 Of autopsy _____
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?
 While at work? _____ (Specify type of place) (e) Means of injury _____
 23. Signature [Signature] (as D. or other) _____
 Address 4501 E. 1st Springfield Mo. Designated 12-2-46

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

MOTHER FATHER

111

(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 Ogle Stone, Jr.
Licensed Embalmer No. 4176
P. O. Address Springfield

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.

Registration District No. 128

Primary Registration District No. 2000

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield
(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 D. McKenzie

3. (b) If veteran name war _____ 3. (c) Social Security No. 8

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 _____
(Month) (Day) (Year)

8. AGE: Years 82 Months _____ Days _____ (If less than one day) _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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 _____
(Burial, cremation, or removal) (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 _____ year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 _____

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) Accident

(b) Date of occurrence November 12, 1946

(c) Where did injury occur? Springfield, Greene, Mo.
(City or town) (County) (State)

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

While at work? Yes (Specify type of place) _____ (e) Means of injury Fall

23. Signature _____ (M. D. or other) M.D.

Address 450 1/2 E. Commercial Date signed 1-6-47

SUPPLEMENTARY

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

39057

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

40243