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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED JAN 23 1947  
128

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 816  
Registrar's No. 17

Registration District No. \_\_\_\_\_ Primary Registration District No. 2000

1. PLACE OF DEATH:  
(a) County GREENE  
(b) City or town Springfield Rural  
(c) Name of hospital or institution Greene County Hospital Springfield  
(d) Length of stay: In hospital or institution. 0 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Jasper 39  
(c) City or town Walnut Grove Mo 0  
(d) Street No. 1  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Robert Nathan McKinney  
3. (b) If veteran, name war nil  
3. (c) Social Security No. nil

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month January day 6 year 1947 hour 11 minute 15 A.M.  
21. I hereby certify that I attended the deceased from Sept. 1942 to Jan. 1947 that I last saw him alive on Feb. 4, 1947 and that death occurred on the date and hour stated above.

4. Sex Male D 5. Color or race white  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased July 22 1898 (Month) (Day) (Year)

Immediate cause of death Arteriosclerosis, Cerebral  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

8. AGE: Years 68 Months 5 Days 14 If less than one day hr. min.

Other conditions: Paralysis agitans (Include pregnancy within 3 months of death)  
Major findings: Vertical Blindness  
Of operations \_\_\_\_\_  
Of autopsy 97  
PHYSICIAN \_\_\_\_\_ Underline the cause to which death should be charged statistically.

MOTHER FATHER

9. Birthplace Ky. 1 (City, town, or county) (State or foreign country)  
10. Usual occupation Farmer  
11. Industry or business General Farm Laborer  
12. Name John Franklin McKinney  
13. Birthplace Ky. 1 (City, town, or county) (State or foreign country)  
14. Maiden name Sarah L. Bray  
15. Birthplace Ky. 1 (City, town, or county) (State or foreign country)

16. (a) Informant N. A. McKinney  
(b) Address Walnut St. W. Mo  
17. (a) Burial Date thereof 1-10-47 (Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Greenlawn Cemetery  
18. (a) Signature of funeral director James A. Parrott  
(b) Address Walnut Grove Mo  
19. (a) 1-9-47 (Date received local registrar) N. J. Handley MD (Registrar's signature)

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) \_\_\_\_\_  
Means of injury \_\_\_\_\_  
23. Signature James R. Amos (M. D. or other) MD  
Address Springfield Mo. Date signed 1-9-47

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

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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.....

*James A. Jones*

Licensed Embalmer No. *7664*

P. O. Address.....

*Valent Linn. 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.