

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAR 28 1947

Registration District No. 2000

Primary Registration District No. 2000

Registrar's No. 199

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:
602 N Weaver Str.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community 70 Years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. 602 N Weaver Str.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Thomas M McKinney

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

4. Sex Male 5. Color or race Col. 6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife Mary M McKinney 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased August 1 1857
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
89 7 3 hr. min.

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

10. Usual occupation Stone Mason

11. Industry or business _____

MOTHER FATHER

12. Name Unknown Unknown?

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

14. Maiden name Maria M McKinney

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

16. (a) Informant Adah Fulbright

(b) Address 1126 Sherman Str.

17. (a) Burial (b) Date thereof 3 7 '47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hazelwood Cem.

18. (a) Signature of funeral director W. P. Campbell

(b) Address 867 Washington Ave.

19. (a) 3-2-47 (b) M. Handley M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 5
year 1947 hour 9:40 minute _____ M.

21. I hereby certify that I attended the deceased from 3-11 1947 to 3-5 1947

that I last saw him alive on 3-2 1947 and that death occurred on the date and hour stated above.

Immediate cause of death myocardial infarction with deceleration
Duration 3 mos.

Due to _____

Due to _____

Other conditions Senility
(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? _____

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

23. Signature A. S. Feller (M. D. or other) _____

Address Springfield Date signed 3/27/47

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

9
2
6

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 W. P. Campbell

Licensed Embalmer No. 11747

P. O. Address Springfield 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.