

Registration District No. 236

Primary Registration District No. 5218

Registrar's No. 27

1. PLACE OF DEATH:

(a) County Morgan  
(b) City or town Rural Barnett MO  
(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 1 Year  
In this community 1 Year  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Morgan  
(c) City or town Rural Barnett MO  
(d) Street No. \_\_\_\_\_  
(e) Citizen of foreign country? No  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME ELLA D. MCKINLEY

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife William Mc Kinley 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased May 15, 1890  
(Month) (Day) (Year)

8. AGE: Years 56 Months 11 Days 29  
If less than one day hr. min.

9. Birthplace Morgan CO Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation House Wife

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name John Turpin

13. Birthplace Morgan CO MO  
(City, town, or county) (State or foreign country)

14. Maiden name Hena Moore

15. Birthplace Morgan CO MO  
(City, town, or county) (State or foreign country)

16. (a) Informant WM Mc Kinley  
(b) Address Barnett MO

17. (a) Removal (b) Date thereof 5-14-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cem Sedalia MO

18. (a) Signature of funeral director Wm. Washburn  
(b) Address Sedalia MO

19. (a) 5-17-47 (b) Wm. Washburn  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 14th  
year 1947 hour 1 minute A.M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_,  
and that death occurred on the date and hour stated above.

Immediate cause of death Psychic Shock Duration \_\_\_\_\_  
1st one year ago 1946.  
2nd May 8th 1947  
Due to 3 May 13th 1947.

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? 3

While at work? \_\_\_\_\_  
(Specify type of place) (c) - Means of injury \_\_\_\_\_

23. Signature Rich L. Hudson (M. D. or other) \_\_\_\_\_  
Address Kennett Mo. Date signed 5/14/47

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

RECEIVED  
District Health Officer No. 7,  
District File Number 4-47-619  
Date Filed 5-29-47

**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 *Duane Ewing*

Licensed Embalmer No. *3847*

P. O. Address *Sidalia, 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.**