No. 2
1-47
17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED APR 16 1948
Registration District No. 188

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 12016
Primary Registration District No. 5392
Registrar's No. 26

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

1. PLACE OF DEATH:
(a) County Dent
(b) City or town Lenox
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: None
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution --
(Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED: 999
(a) State Iowaouri (b) County St. Anthony 13
(c) City or town 0
(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 No

3. (a) PRINT FULL NAME George C. McKinney
3. (b) If veteran, name war ----
3. (c) Social Security No. ---

4. Sex Male 0
5. Color or race White
6. (a) Single, widowed, married, divorced Married 1
6. (b) Name of husband or wife Iona McKinney
6. (c) Age of husband or wife if alive 56 years
7. Birth date of deceased May (Month) 30 (Day) 1892 (Year)

8. AGE: Years	Months	Days	If less than one day
55	9	29	hr. min.

9. Birthplace Sullivan County (City, town, or county) Missouri 0 (State or foreign country)
10. Usual occupation Farmer
11. Industry or business

MOTHER FATHER
12. Name John C. McKinney
13. Birthplace Virginia 1 (City, town, or county) (State or foreign country)
14. Maiden name Mary E. Linhart
15. Birthplace Missouri 0 (City, town, or county) (State or foreign country)

16. (a) Informant Iona McKinney
(b) Address St. Anthony, Iowa
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/31/48 (Month) (Day) (Year)
(c) Place: burial or cremation Marshalltown Iowa
18. (a) Signature of funeral director Earl F. Spencer
(b) Address Salem, Missouri
19. (a) 3-30-48 (Date received by local registrar) (b) M. M. Hart M.D. by MCH (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 29
year 1948 hour 5:00 minute P.M.
21. I hereby certify that I attended the deceased from Not seen to alive, 19...; that I last saw h... alive on ..., 19...; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral concussion	—
Due to flow on head	
Due to	
Other conditions Possible skull fracture (Include pregnancy within 3 months of death)	

Major findings:
Of operations —
Of autopsy —

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

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) homicide
(b) Date of occurrence 3-29-48
(c) Where did injury occur? Lenox (City or town) Dent (County) Mo. (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public place (store) (Specify type of place)
While at work? no (e) Means of injury —

23. Signature M. M. Hart M.D. (M. D. or other) M.D.
Address Salem, Mo. Date signed 3/30/48
Coroner

Jefferson City Printing Co.
(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 5,
District File Number 44.8230
Date Filed 4-13-48

NOV 1 1954

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 Wm. W. McDonald

Licensed Embalmer No. 3806

P. O. Address Salem, 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.