

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **14406**
Registrar's No. **3323**

FILED APR 23 1948

Registration District No.

318

Primary Registration District No.

1003

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution 4803 Fountain Ave.
(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

Frank M. McKinney

3. (b) If veteran,
name war No

3. (c) Social Security No.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Ruby McKinney 6. (c) Age of husband or wife if alive 51 years
7. Birth date of deceased March 7 1889
(Month) (Day) (Year)

8. AGE: Years 59 Months 0 Days 29 If less than one day
hr. min.

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

10. Usual occupation Salesman

11. Industry or business Coca-Cola Co.

12. Name William Earl McKinney
13. Birthplace Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ruby McKinney

(b) Address 4803 Fountain Ave.

17. (a) Burial (b) Date thereof 4-9-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) APR 7 1948 (b) J. F. Brudeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County no
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 4803 Fountain Ave. 9
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No) 0
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 6
year 1948 hour 7 minute 00 AM.

21. I hereby certify that I attended the deceased from May 14, 1948, to April 6, 1948.
that I last saw him alive on April 5, 1948,
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion Duration Sudden

Due to 9/4
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations No Of autopsy No
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) No
(b) Date of occurrence No
(c) Where did injury occur? No
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place) While at work? _____ (e) Means of injury 0

23. Signature James C. M. John (M. D. or other) M.D.
Address Metropolitan Bldg. Date signed 4/6/48

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

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.....

Licensed Embalmer No.....

P. O. Address.....

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.