

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26964

State File No. 3351

FILED AUG 21 1949

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>KANSAS</u> b. COUNTY <u>WYANDOTTE</u>	
b. CITY OR TOWN <u>KANSAS CITY</u>	c. LENGTH OF STAY (in this place) <u>4 DAYS</u>	c. CITY OR TOWN <u>KANSAS CITY</u>	d. STREET ADDRESS (If rural, give location) <u>805 ANN AVE</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>3700 TRACY AVE #3</u>			
3. NAME OF DECEASED a. (First) <u>JOHN</u> b. (Middle) _____ c. (Last) <u>MCKINNEY</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>8-2-1949</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER/MARRIED, WIDOWED, DIVORCED (Specify) <u>NEVER MARRIED</u>	8. DATE OF BIRTH <u>May 24 1860</u>
9. AGE (In years last birthday) <u>89</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>	11. BIRTHPLACE (State or foreign country) <u>Ireland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>John McKinney</u>	13b. MOTHER'S MAIDEN NAME <u>Katherine Kennedy</u>	14. NAME OF HUSBAND OR WIFE <u>NONE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NONE</u>	16. SOCIAL SECURITY NO. <u>NO.</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>MRS L. G. AIGAIER SR. K.C. KS.</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial failure</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause. (a) stating the underlying cause last. DUE TO (b) <u>Senile Dementia on</u> DUE TO (c) <u>Arteriosclerotic Basis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>4221</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>7/9</u> , 19 <u>49</u> , to <u>8/2</u> , 19 <u>49</u> that I last saw the deceased alive on <u>7/20</u> , 19 <u>49</u> , and that death occurred at <u>3:30A.M.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>J. R. Nolan</u> (Degree or title) <u>M.D.</u>		23b. ADDRESS <u>314 Brotherhood Bldg</u>	23c. DATE SIGNED <u>8/3/49</u>
24a. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>8-4-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHN'S CEMETERY</u>	24d. LOCATION (City, town, or county) (State) <u>KANSAS CITY, KS.</u>
DATE REC'D BY LOCAL REG. <u>8-3-49</u>	REGISTRAR'S SIGNATURE <u>Deraldine Holmes</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>F. A. Raising K.C. Mo.</u>	

WRITE PLAINLY—USING 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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed George A. Reising

Signed _____
Student Embalmer

Licensed Embalmer No. 4458

P. O. Address Kansas City, 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.