

FILED MAR 20 1950

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. 8838
 786

BIRTH NO. 14992-50 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>Fairmount Hospital Jackson Co.</u> b. COUNTY _____	
b. CITY OR TOWN <u>Kansas City Mo.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City Mo.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>The Children's Mercy Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>27 + Paseo</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Miles</u> b. (Middle) _____ c. (Last) <u>McKinney</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>2-17-50</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Child</u>	8. DATE OF BIRTH <u>2-6-50</u>
9. AGE (In years last birthday) _____		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 4 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>17 foot</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <u>Fairmount Hospital - K.C. Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME _____		13b. MOTHER'S MAIDEN NAME <u>Doraine McKinney (unmarried)</u>	
14. NAME OF HUSBAND OR WIFE _____		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>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Eva Thomson - Fairmount Hosp. K.C. Mo.</u>		ADDRESS _____	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Atalectasis of lung</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Aspirated food</u> DUE TO (c) _____ 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 _____	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? _____		21f. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from <u>2-11</u> , 1950, to <u>2-17</u> , 1950, that I last saw the deceased alive on <u>2-17</u> , 1950, and that death occurred at <u>12:20 P. M.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>H. M. Gilkey</u> (Degree or title) _____		23b. ADDRESS <u>1624 Prof Bldg.</u>	
23c. DATE SIGNED <u>2-17-50</u>		23c. DATE SIGNED <u>2-17-50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Feb-21-50</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Green Lawn</u>		24d. LOCATION (City, town, or county) (State) <u>Hickman Mo Mo</u>	
DATE REC'D BY LOCAL REG. <u>2-20-50</u>		REGISTRAR'S SIGNATURE <u>Sheraldine Holmes</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>A. P. Dorschler</u>		ADDRESS <u>1415 E 15</u>	

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

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.....

Not Embalmed

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed *J.P. Doehler*

Licensed Embalmer No. *1166*

P. O. Address: *1415 E 15*

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.