

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19712

State File No.

FILED JUL 6 1950

BIRTH NO. 48030-49 REG. DIST. NO. 71 PRIMARY REG. DIST. NO. 3012 Registrar's No. 22

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| 1. PLACE OF DEATH a. COUNTY <u>Clay</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u> | |
| b. CITY (If outside corporate limits, write RURAL and give township) <u>Excelsior Springs</u> | | c. CITY (If outside corporate limits, write RURAL and give township) <u>Excelsior Springs</u> | |
| c. LENGTH OF STAY (in this place) <u>12 mo.</u> | | d. STREET ADDRESS (If rural, give location) <u>422 East Excelsior St</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>422 East Excelsior St</u> | | | |

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|--|-------------|-----------|--|--|--|
| 3. NAME OF DECEASED (Type or Print) <u>DONALD GENE KINNEY</u> | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>June 14, 1950</u> | | |
| a. (First) | b. (Middle) | c. (Last) | | | |

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|---|---|--|--|---|---|--|
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Baby</u> | 8. DATE OF BIRTH <u>June 30 1949</u> | 9. AGE (to years last birthday) <u>11 1/4</u> | IF UNDER 1 YEAR Months <u>11</u> Days <u>14</u> | IF UNDER 4 HRS. Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>no</u> | 11. BIRTHPLACE (State or foreign country) <u>Excelsior Springs Mo.</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |

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| 13a. FATHER'S NAME <u>Donald O. Kinney</u> | 13b. MOTHER'S MAIDEN NAME <u>Mamie Ditton</u> | 14. NAME OF HUSBAND OR WIFE <u>none Baby</u> |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) <u>no</u> | 16. SOCIAL SECURITY NO. <u>no</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>Donald O. Kinney</u> | ADDRESS <u>422 E. Excelsior</u> |
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| 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, asthenia, etc. It means the disease, injury, or complication which caused death. | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Palsy</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>12 months</u> |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cause undetermined - no</u> DUE TO (c) <u>evidence of birth injury.</u> | | |
| | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>(Supp. report)</u> | | |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
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| 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) |
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| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |
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22. I hereby certify that I attended the deceased from 3-14, 1950, to 6-14, 1950, that I last saw the deceased alive on 6-14, 1950, and that death occurred at 12 1/2 m., from the causes and on the date stated above.

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| 23a. SIGNATURE <u>Urgil St. Rohlfing</u> (Degree or title) <u>no.</u> | 23b. ADDRESS <u>116 South - Excelsior Springs Mo.</u> | 23c. DATE SIGNED <u>6/14/50</u> |
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| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 24b. DATE <u>June 15/50</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Cemetery</u> | 24d. LOCATION (City, town, or county) (State) <u>Sedalia, Mo.</u> |
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| DATE REC'D BY LOCAL REG. <u>6/15/50</u> | REGISTRAR'S SIGNATURE <u>Caroline Hutchings</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Urgil St. Rohlfing</u> | ADDRESS <u>Hope Funeral Home, Exc. Spgs. Mo.</u> |
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WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

300
48

RECEIVED JUN 28
District Health Officer No. 8,

District File Number _____

Date Filed 6-29-50

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.

Student
Student Embalmer

Signed: Chas Virgil Pope

Licensed Embalmer No. 3950

P. O. Address Excelsior Springs

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.