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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

BIRTH NO. 73843-54 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No.

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (In this place) <u>11 hrs 40 min</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Homer G. Phillips</u>			d. STREET ADDRESS (If rural, give location) <u>2/ 3302 Pine</u>		

3. NAME OF DECEASED (Type or Print)			a. (First)		b. (Middle)		c. (Last)		4. DATE OF DEATH (Month) (Day) (Year)		
							<u>McKinney</u>		<u>9 23 54</u>		
5. SEX <u>Fem.</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH <u>9-22-54</u>		9. AGE (In years last birthday)		IF UNDER 1 YEAR Months Days	
										<u>11 40</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>				12. CITIZEN OF WHAT COUNTRY? <u>0</u>	

13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME <u>Gloria Dean McKinney</u>		14. NAME OF HUSBAND OR WIFE	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME <u>Beth W. Sheward</u>		ADDRESS <u>2601 N. Whittier</u>	
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18. CAUSE OF DEATH Enter only one cause of death per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Premature birth, neonatal death</u>					
		ANTECEDENT CAUSES					
		*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.					
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.					
		DUE TO (b) _____					
		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 type="checkbox"/> NO <input checked="" 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)	
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? <u>7735</u>	

22. I hereby certify that I attended the deceased from 9-22-, 1954, to 9-23-, 1954 that I last saw the deceased alive on 9-23-, 1954 and that death occurred at 1:35 am., from the causes and on the date stated above.

23a. SIGNATURE <u>William H. Sinkler</u>		(Degree or title) <u>M. D.</u>		23b. ADDRESS <u>2601 N. Whittier</u>		23c. DATE SIGNED <u>9-29-54</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>10-30-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>	
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DATE REC'D BY LOCAL REG. <u>OCT 20 1954</u>		REGISTRAR'S SIGNATURE <u>Carl Smith MD</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Rowland-Aker Mortuary Service</u>		ADDRESS <u>4104 Manchester Ave. St. Louis 10, Mo.</u>	
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(Licensed Embalmer's Statement on Reverse Side)

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

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.