

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 14714

FILED JUN 13 1955

BIRTH NO. REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 567

3

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

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Joseph</b>		c. LENGTH OF STAY (In this place) <b>none</b>	c. CITY OR TOWN <b>Rushville</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>D.O.A. Most Metho. Hospital</b>		• STREET ADDRESS (If rural, give location) <b>Rt #2</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>Ralph</b> b. (Middle) <b>T.</b> c. (Last) <b>McKinnie</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>May 23 1955</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>July 8, 1896</b>
9. AGE (In years last birthday) <b>58</b>	IF UNDER 1 YEAR Months <b>10</b> Days <b>15</b>	IF UNDER 1 HR. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Service Station</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Iowa</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13a. FATHER'S NAME <b>Unknown</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Mabel McKinnie</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>no</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Maxine Turner, Rushville, Mo</b>	
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) <b>Coronary Occlusion</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Diabetes Mellitus</b> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs.</b> <b>6 yrs.</b> <b>6 yrs.</b>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>4/201</b>		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) m.	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 <b>Sept 28 1950</b> to <b>Apr 19 1955</b> that I last saw the deceased alive on <b>Apr 22 1955</b> , and that death occurred at <b>6:20</b> m., from the causes and on the date stated above.			
23a. SIGNATURE <b>Robert H. Korman MD</b>		23b. ADDRESS <b>St Joseph Mo</b>	23c. DATE SIGNED <b>5/26/55</b>
24a. BURIAL, CREMATION REMOVAL (Specify)	24b. DATE <b>5/26/55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Morrill Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Morrill Kansas</b>
DATE REC'D BY LOCAL REG. <b>June 9, 1955</b>	REGISTRAR'S SIGNATURE <b>Esther M. Allison</b>	485	5. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Shute Rupp, 6054 Pryor Ave., St. Joseph, Mo.</b>

(Licensed Embalmer's Statement on Reverse Side)

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 .....  
Signature of Student Embalmer

Signed *Allen C. Bryan*

Licensed Embalmer No. *479*

P. O. Address *St. Joseph*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.