

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25048

State File No.

FILED AUG 1 - 1955

BIRTH NO. _____ REG. DIST. NO. 381 PRIMARY REG. DIST. NO. 4515 Registrar's No. 50

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

1. PLACE OF DEATH a. COUNTY SULLIVAN		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY SULLIVAN	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN MILAN		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN POLLOCK	
c. LENGTH OF STAY (in this place) 27 days		d. STREET ADDRESS (If rural, give location) 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION SULLIVAN COUNTY MEMORIAL			

3. NAME OF DECEASED (Type or Print)	a. (First) SAMUEL	b. (Middle) JACKSON	c. (Last) MCK INSEY	4. DATE OF DEATH (Month) (Day) (Year)
				7 20 1955

5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 1-8-1881	9. AGE (In years last birthday) 74	IF UNDER 1 YEAR Months 6 Days 13	IF UNDER 2 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MISSOURI	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME DAVE MCKINSEY	13b. MOTHER'S MAIDEN NAME LUCINDA BLUE	14. NAME OF HUSBAND OR WIFE ANNA MCKINSEY
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Bob McKinsey, Pollock, Mo	ADDRESS
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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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ca of Lung		INTERVAL BETWEEN ONSET AND DEATH 1 yr 9 hrs
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral Embolus		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 163X			

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)
		Pollock, Sullivan, Mo

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?
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22. I hereby certify that I attended the deceased from June 14, 1955, to July 20, 1955, that I last saw the deceased alive on July 20, 1955, and that death occurred at 10 P. M., from the causes and on the date stated above.

23a. SIGNATURE Charles S. McMillan M.D.	(Degree or title)	23b. ADDRESS Pollock, Mo	23c. DATE SIGNED 7/22/55
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24a. BURIAL, CREMATION, REMOVAL (Specify) SULLIVAN	24b. DATE 7/22/55	24c. NAME OF CEMETERY OR CREMATORY Elmwood Cem	24d. LOCATION (City, town, or county) (State) Sullivan Co. Mo.
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DATE REC'D BY LOCAL REG. 7-23-1955	REGISTRAR'S SIGNATURE Mrs. H. B. Harris	3200	25. FUNERAL DIRECTOR'S SIGNATURE Wm. Schoene	ADDRESS Nuber Mo
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AUG 24 1958

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.....

Dwight Schoene

Licensed Embalmer No. *2667*

P. O. Address *Milan 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.