

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED NOV 13 1957

36930
STATE FILE NUMBER

Registration District No. 282 Primary Registration District No. 5977 Registrar's No. 117

S. 300
v. 1-57

1. PLACE OF DEATH a. COUNTY <u>Polk</u>		2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Polk</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Aldrich</u>		c. CITY OR TOWN <u>Aldrich</u>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Lifetive</u>		d. STREET ADDRESS (If outside, give location) <u>541</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Length of stay in 1b <u>Lifetime</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>OLEN</u> Middle <u>ROY</u> Last <u>McKINNEY</u>			4. DATE OF DEATH Month <u>Oct</u> Day <u>24</u> Year <u>1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 29 - 1901</u>	9. AGE (In years last birthday) <u>56</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>6</u>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager Farmers Exchange</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Exchange</u>	11. BIRTHPLACE (City and state or country) <u>Aldrich, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Tom McKinney</u>	13b. MOTHER'S MAIDEN NAME <u>Mollie Kroger</u>	14. NAME OF HUSBAND OR WIFE <u>Osa McKinney</u>
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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) <u>yes</u> <u>W.W. II</u>	16. SOCIAL SECURITY NO. <u>49505-9232</u>	17. INFORMANT <u>Osa McKinney - Aldrich Mo.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>massive coronary occlusion 1 hr</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____ DUE TO (c) _____	
PART-II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4201</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____
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21. I attended the deceased from Oct 20 to Oct 24 and last saw ^{her}him alive on Oct 24
Death occurred at 8:05 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Debra Crow</u> (Degree or title)	22b. ADDRESS <u>Balvan Mo</u>	22c. DATE SIGNED <u>11-4-57</u>
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23a. BURIAL, CREMATION, REMAINS (Specify)	23b. DATE <u>Oct 28-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Ridge Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Aldrich Mo</u>
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24. FUNERAL DIRECTOR <u>Brun - Daniel - Walnut Grove - Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Nov. 9, 1957</u>	26. REGISTRAR'S SIGNATURE <u>Ralph Jordan per Judith Jordan</u>
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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

MAR 14 1958

DEC 8 1957

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 *Boyle L. David*

Licensed Embalmer No. *4702*

P. O. Address *St. George, N.H.*

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.