

FILED MAY 2 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-014311

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1884

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>KANSAS CITY</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>V A HOSPITAL</b>		Length of stay in lb <b>2 years</b>	d. STREET ADDRESS (If outside, give location) <b>129 EAST 46TH</b>

3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM LAWRENCE MC KINLEY</b>			4. DATE OF DEATH Month Day Year <b>April 11, 1958</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 16, 1889</b>	9. AGE (In years last birthday) <b>68</b>	FUNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Warehouseman - RETIRED</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>SALESMAN</b>	11. BIRTHPLACE (City and state or country) <b>Des Moines, Iowa</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>William McKinley</b>	13b. MOTHER'S MAIDEN NAME <b>Mary McCauley</b>	14. NAME OF HUSBAND OR WIFE <b>Ruth A. McKinley</b>
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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) <b>YES W.W. #1</b>	16. SOCIAL SECURITY NO. <b>478-01-0466</b>	17. INFORMANT Address <b>129 EAST 46th ST. KANSAS CITY, MO.</b>
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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) <b>Acute bronchopneumonia, right lower lobe</b>		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) <b>Carcinoma of the rectum, operated, with metastases to brain</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Month, Day, Year a.m. p.m.
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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. attended the deceased from **February 28, 1958**, to **April 11, 1958** and **occasionally**  
Death occurred at **5:45 a m** on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>ROBERT FLINNER, M.D.</b> (Degree or title)	22b. ADDRESS <b>V A Hospital, Kansas City, Mo.</b>	22c. DATE SIGNED <b>4-11-58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>APRIL 14, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet</b>	23d. LOCATION (City, town, or county) (State) <b>KANSAS CITY, MISSOURI</b>
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24. FUNERAL DIRECTOR <b>D.W. NEWCOMER'S SONS</b> ADDRESS <b>1331 BRUSH CREEK KANSAS CITY, MO</b>	25. DATE RECD. BY LOCAL REG. <b>4-12-58</b>	26. REGISTRAR'S SIGNATURE <b>Neva Minshall</b>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Locust, Coroner, etc. must use any standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.



STATE OF NORTH CAROLINA  
 DEPARTMENT OF HEALTH  
 DIVISION OF VITAL RECORDS

DATE OF DEATH: \_\_\_\_\_ TIME OF DEATH: \_\_\_\_\_  
 PLACE OF DEATH: \_\_\_\_\_  
 COUNTY: \_\_\_\_\_ CITY/TOWN: \_\_\_\_\_  
 NAME OF DECEASED: \_\_\_\_\_  
 SEX: \_\_\_\_\_ AGE: \_\_\_\_\_  
 OCCUPATION: \_\_\_\_\_  
 CAUSE OF DEATH: \_\_\_\_\_  
 MANNER OF DEATH: \_\_\_\_\_

**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 James W. Thayer  
 \_\_\_\_\_

Licensed Embalmer No. 4207

P. O. Address N.C. 270

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.