

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-005725

STATE FILE NUMBER

FILED FEB 27 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 806

300  
1-57 3

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>27th &amp; Manchester</b>		Length of stay in 1b <b>Life</b>	d. STREET ADDRESS <b>9304 Grandview Rd</b>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First <b>ROBERT</b>	Middle <b>JEAN</b>	Last <b>McKINNEY</b>	Month <b>February</b>	Day <b>11</b>	Year <b>1959</b>

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 11 1933</b>	9. AGE (In years last birthday) <b>25</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Service Sta Attend</b>	11. BIRTHPLACE (City and state or country) <b>Kansas City Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>William R McKinney</b>	13b. MOTHER'S MAIDEN NAME <b>Stella Emens</b>	14. NAME OF HUSBAND OR WIFE <b>Delores Jean McKinney</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>No</b>	16. SOCIAL SECURITY NO. <b>---</b>	17. INFORMANT <b>William R McKinney 9304 Grandview RD K C Mo</b>	Address
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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>Spikes &amp; Hemlock resulting from crushing of</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), starting the underlying cause last.	DUE TO (b) <b>Spent time multiple sub. fracture, hemorrhage, hemorrhage &amp; laceration of myocardium</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 <input checked="" 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.) <b>Car ran off street &amp; down embankment</b>
20c. TIME OF INJURY <b>8-20 p.m. 2-11-59</b>	

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>	20f. CITY, TOWN, OR LOCATION <b>Kansas City</b>	COUNTY <b>Jackson</b>	STATE <b>Mo</b>
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21. I attended the deceased from \_\_\_\_\_, to \_\_\_\_\_ and last saw <sup>her</sup> him alive on \_\_\_\_\_  
Death occurred at \_\_\_\_\_ on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Geo C Kealhofer</b>	(Degree or title) <b>3</b>	22b. ADDRESS <b>6677 Market St Mo</b>	22c. DATE SIGNED <b>2-12-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>2/15/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Green Lawn Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City Missouri</b>
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24. FUNERAL DIRECTOR <b>Sheil Funeral Home Kansas City Mo</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>2-12-59</b>	26. REGISTRAR'S SIGNATURE <b>new minshall</b>
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Geo. C. Kealhofer



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 *Thomas A. Schil* .....

Licensed Embalmer No. *4954* .....  
P. O. Address *J. C. Moore* .....

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.