

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-021940

STATE FILE NUMBER

LEU JUN 23 1959 Registration District No. 155 Primary Registration District No. 5577 Registrar's No. 92

1. PLACE OF DEATH a. COUNTY Jasper		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jasper	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Jasper Twpsh.		c. CITY OR TOWN E. OF OPOLIS KS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION E. OF OPOLIS, KS		d. STREET ADDRESS (If outside, give location) East of Mo State Line	
3. NAME OF DECEASED (Type or print) First Middle Last Lewis Edgort McKinnis		4. DATE OF DEATH Month Day Year 6-13-1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-15-1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		11. BIRTHPLACE (City and state or country) Frankfort Kentucky	
13a. FATHER'S NAME Hughey McKinnis		14. NAME OF HUSBAND OR WIFE Libbey B. McKinnis (decd)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war and dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address DAVID Monroe McKinnis, Opolis KS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Medullary Failure DUE TO (b) Cerebral Hemorrhage DUE TO (c) Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 3 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 331X			
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.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT WORK <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	
21. I attended the deceased from Sept 1958 to June 13, 1959 and last saw him alive on June 13, 1959. Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE L. E. Stiles (Degree or title)		22b. ADDRESS Carl Junction Mo	
		22c. DATE SIGNED 6/15/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 6-16-1959	
23c. NAME OF CEMETERY OR CREMATORY Glocker Cemetery		23d. LOCATION (City, town, or county) (State) 2 mi West Mo Line in KS.	
24. FUNERAL DIRECTOR Don Roney		25. DATE RECD. BY LOCAL REG. 6-16-59	
ADDRESS Carl Junction Mo		26. REGISTRAR'S SIGNATURE Mrs. Madeline Switzer	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

L. E. Stiles - D. O.

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 *Jack C. Simpson*
Licensed Embalmer No. *4647*
P. O. Address *Webb City*

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.