

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031374

FILED VS OCT 2 1959

Registration District No. 10 Primary Registration District No. 3002 Registrar's No. 192

STATE FILE NUMBER

INDEXED

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|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|------------------------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Anderson</u>                                                                                                                                              |                                                                                                                         |                                                                                                                                                             |                                                                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Anderson</u> |                                                                       |                                                                                                                                                                                 |                                                                                       |                                    |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Mexico</u>                                                                                                          |                                                                                                                         | Length of stay in 1b<br><u>10 1/2 yrs.</u>                                                                                                                  |                                                                                      | c. CITY OR TOWN <u>Mexico</u>                                                                                                               |                                                                       | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                                                            |                                                                                       |                                    |  |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>516 Ladd St.</u>                                                                                          |                                                                                                                         |                                                                                                                                                             | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |                                                                                                                                             | d. STREET ADDRESS (If outside, give location)<br><u>516 Ladd St.</u>  |                                                                                                                                                                                 | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |                                    |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>LILLIE MAE MCKINNON</u>                                                                                                      |                                                                                                                         |                                                                                                                                                             |                                                                                      | 4. DATE OF DEATH<br>Month Day Year<br><u>Sept 25-1959</u>                                                                                   |                                                                       |                                                                                                                                                                                 |                                                                                       |                                    |  |
| 5. SEX<br><u>Female</u>                                                                                                                                                                     | 6. COLOR OR RACE<br><u>Negro</u>                                                                                        | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |                                                                                      | 8. DATE OF BIRTH<br><u>July 1-1906</u>                                                                                                      | 9. AGE (last birthday)<br><u>53 yrs.</u>                              | IF UNDER 1 YEAR<br>Months Days Hours Min.                                                                                                                                       | IF UNDER 24 HR                                                                        |                                    |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>housewife</u>                                                                             |                                                                                                                         |                                                                                                                                                             | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>owned &amp; operated</u>                     |                                                                                                                                             | 11. BIRTHPLACE (City and state or country)<br><u>Little Rock Ark.</u> |                                                                                                                                                                                 | 12. CITIZEN OF WHAT COUNTRY<br><u>U.S.A.</u>                                          |                                    |  |
| 13a. FATHER'S NAME<br><u>Berry Macan</u>                                                                                                                                                    |                                                                                                                         |                                                                                                                                                             | 13b. MOTHER'S MAIDEN NAME<br><u>Ida Mae Sudder</u>                                   |                                                                                                                                             |                                                                       | 14. NAME OF HUSBAND OR WIFE<br><u>William D. McKinnon</u>                                                                                                                       |                                                                                       |                                    |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>no</u>                                                                       |                                                                                                                         |                                                                                                                                                             | 16. SOCIAL SECURITY NO.<br><u>unknown</u>                                            |                                                                                                                                             | 17. INFORMANT<br><u>William D. McKinnon, Mexico, Mo.</u>              |                                                                                                                                                                                 |                                                                                       | Address                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u>                                |                                                                                                                         |                                                                                                                                                             |                                                                                      |                                                                                                                                             |                                                                       |                                                                                                                                                                                 | INTERVAL BETWEEN ONSET AND DEATH                                                      |                                    |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <u>hypertension</u>                                                                |                                                                                                                         |                                                                                                                                                             |                                                                                      |                                                                                                                                             |                                                                       |                                                                                                                                                                                 |                                                                                       |                                    |  |
| DUE TO (c)                                                                                                                                                                                  |                                                                                                                         |                                                                                                                                                             |                                                                                      |                                                                                                                                             |                                                                       |                                                                                                                                                                                 |                                                                                       |                                    |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)                                                           |                                                                                                                         |                                                                                                                                                             |                                                                                      |                                                                                                                                             |                                                                       | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |                                                                                       |                                    |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                           | 20a. ACCIDENT SUICIDE HOMICIDE<br><input checked="" 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.)                                                |                                                                       |                                                                                                                                                                                 |                                                                                       |                                    |  |
| 20c. TIME OF INJURY<br>Hour a.m. p.m.                                                                                                                                                       |                                                                                                                         | Month, Day, Year                                                                                                                                            |                                                                                      |                                                                                                                                             |                                                                       |                                                                                                                                                                                 |                                                                                       |                                    |  |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/><br>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 <u>1-5-59</u> to <u>9-25-59</u> and last saw her <u>live</u> <u>5-A</u> on the date stated above, and to the best of my knowledge, from the causes stated. |                                                                                                                         |                                                                                                                                                             |                                                                                      |                                                                                                                                             |                                                                       |                                                                                                                                                                                 |                                                                                       |                                    |  |
| 22a. SIGNATURE (Degree or title)<br><u>Dr. J. C. Estor, M.D.</u>                                                                                                                            |                                                                                                                         |                                                                                                                                                             |                                                                                      | 22b. ADDRESS<br><u>Mexico, Mo</u>                                                                                                           |                                                                       |                                                                                                                                                                                 |                                                                                       | 22c. DATE SIGNED<br><u>9-26-59</u> |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                   |                                                                                                                         | 23b. DATE<br><u>Sept. 29-1959</u>                                                                                                                           |                                                                                      | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Elmwood</u>                                                                                        |                                                                       | 23d. LOCATION (City, town, or county) (State)<br><u>Mexico, Mo.</u>                                                                                                             |                                                                                       |                                    |  |
| 24. FUNERAL DIRECTOR<br><u>Mrs. Stuart Parker, Columbia, Mo</u>                                                                                                                             |                                                                                                                         |                                                                                                                                                             |                                                                                      | 25. DATE RECD. BY LOCAL REG.<br><u>Sept 26-1959</u>                                                                                         |                                                                       | 26. REGISTRAR'S SIGNATURE<br><u>Blenche Neely</u>                                                                                                                               |                                                                                       |                                    |  |

DOCUMENT

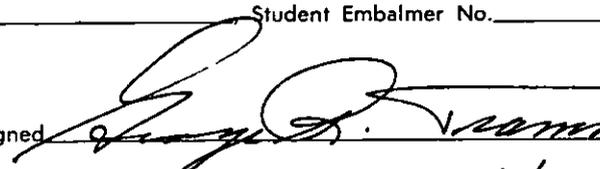
MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_ Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed  \_\_\_\_\_

Licensed Embalmer No. 425

P. O. Address Columbus

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.