

FEDERAL BUREAU OF INVESTIGATION
 FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-003753

FILED VS JAN 22 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 172** STATE FILE NUMBER

3,8,9,13a-b amended by AFF of granddaughter & decedent's appl for social security acct 9/12/2010
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>St Louis</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St Louis, Mo.</u> Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>City Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St Louis</u> c. CITY OR TOWN <u>St. Louis, Mo.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>2027 R Saltsbury</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>JOSEPH PATE MCKINNEY</u> First <u>Joe</u> Middle <u>Peyton</u> Last _____			4. DATE OF DEATH <u>JAN. 5, 1960</u> Month _____ Day _____ Year _____		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 12, 1884</u>	9. AGE (last birthday) <u>50 75</u>	IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Labor</u>		11. BIRTHPLACE (City and state or country) <u>Franklin County, Mo - U.S.A.</u>	12. CITIZEN OF WHAT COUNTRY _____
13a. FATHER'S NAME <u>Charles Peyton Mc Kinney</u>		13b. MOTHER'S MAIDEN NAME <u>Olivia Chiles Mason</u>		14. NAME OF HUSBAND OR WIFE <u>Widowed</u>	
15. WAS DECEASED EVER IN U.S. ARMED SERVICES (Yes, no, or unknown) (If yes, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO. <u>494-09-9918</u>		17. INFORMANT <u>Jessie McKinney St Clair mo</u> Address _____	
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>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <u>420.0</u>					INTERVAL BETWEEN ONSET AND DEATH _____
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.) _____			
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 <u>Dec. 31, 1959</u> to <u>Jan. 5, 1960</u> and last saw <u>him</u> live on <u>Jan. 5, 1960</u> Death occurred at <u>11:05</u> <u>A.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE _____ (Degree or title) _____			22b. ADDRESS <u>1515 Lafayette Ave</u>		22c. DATE SIGNED <u>1-6-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>Jan 8, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Virginia Minea Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Lone Dell, Mo</u>	
24. FUNERAL DIRECTOR <u>Sherwood W. Kitchell</u> ADDRESS <u>St Clair mo</u>		25. DATE RECD. BY LOCAL REG. <u>JAN 6 1960</u>		26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>	

STATEMENT BY LICENSED EMBALMER

JAN 22 1960
N.Y.C.

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 Shenwood W. Kitchell

Licensed Embalmer No. 3873

P. O. Address St. Clair,

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.