SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

61-021359
2839 STATE FILE NUMBER

AMENDED

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

FILED JUN 28 1961

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | BY AFFIDAVIT OF | DOCUMENT

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City,
Length of stay in 1b: 4 months
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2308 Campbell
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Kansas City, Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 2308 Campbell
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First Ida; Middle; Last McKinney
4. DATE OF DEATH: Month May; Day 31; Year 1961
5. SEX: female
6. COLOR OR RACE: Negro
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 9/15/99
9. AGE (last birthday): 61 Yrs
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): Domestic work
10b. KIND OF BUSINESS OR INDUSTRY: Private family
11. BIRTHPLACE (City and state or country): Tennessee
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: unknown
13b. MOTHER'S MAIDEN NAME: unknown
14. NAME OF HUSBAND OR WIFE: James McKinney
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 315 64 068A
17. INFORMANT Address: James McKinney, K. C. Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Hypertension
DUE TO (c): ____
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. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 Feb. 3, 1961, to May 11, 1961 and last saw her alive on May 10, 1961
Death occurred at at 7:00 P M m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): W. T. Reeves D O
22b. ADDRESS: 3106 Woodland K.C.Mo
22c. DATE SIGNED: 6-6-61

W. T. Reeves

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 6/8/61
23c. NAME OF CEMETERY OR CREMATORY: Local Cemetery
23d. LOCATION (City, town, or county) (State): Wynne, Arkansas

24. FUNERAL DIRECTOR ADDRESS: Mrs. Meek's Mortuary K. C. Mo.
25. DATE RECD. BY LOCAL REG.: 6-7-61
26. REGISTRAR'S SIGNATURE: Ruth Long

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Millard B Paskis

Licensed Embalmer No. 5013

P. O. Address K C. Mo

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