

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-011895

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

207
FILED MAR 26 1962

1. PLACE OF DEATH a. COUNTY Maries		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Maries	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Jefferson township		c. CITY OR TOWN South of Belle Mo.	
Length of stay in lb 15 yrs.		Inside Limits Yes ☐ No ☒	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION At Home		d. STREET ADDRESS (If outside, give location) At Home	
3. NAME OF DECEASED (Type or print) John Andrew Jackson McKinney		4. DATE OF DEATH Month March Day 15 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. Married ☐ Never Married ☐ Widowed ☐ Divorced ☒	8. DATE OF BIRTH 10/12/94
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clay Miner, farmer		10b. KIND OF BUSINESS OR INDUSTRY clay mining	
11a. FATHER'S NAME Tom McKinney		11b. MOTHER'S MAIDEN NAME Malissa Crider	
12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		12b. SOCIAL SECURITY NO. 497-07-9062	
13. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarct DUE TO (b) Arteriosclerotic Coronary Artery disease DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		14. NAME OF HUSBAND OR WIFE divorced	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic Congestive Heart Failure		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.	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 5/13/61 to 3/5/62	
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at 2:30 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE James A. Shea	
22b. ADDRESS Liberty		22c. DATE SIGNED 3/17/62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3/18/62	23c. NAME OF CEMETERY OR CREMATORY Liberty	
24. FUNERAL DIRECTOR Charles Jones, Belle Mo		25. DATE RECD. BY LOCAL REG. 3-19-62	
26. REGISTRAR'S SIGNATURE Mozele Hutchins		27. DATE SIGNED 3/17/62	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DATE AMENDED

USE BLACK INK
OR
TYPEWRITER RIBBONVS 300
Rev. 4/59

1 06.30

2 06.30

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11

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13 1-0

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

Orma L. Hubert Jones

Licensed Embalmer No.

4411

P. O. Address

Bell Me.

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.