

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**62-027235**

**3790**

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. **149**

Primary Registration District No. **1002**

Registrar's No.

**FILED AUG 2 1962**

VS 300  
Rev. 4/59

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2 **0192**  
+ **122**

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11  
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13

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Cass</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>44 days</b>	c. CITY OR TOWN <b>Harrisonville</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Trinity Lutheran Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>400 N. Independence</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ALBERT</b> Middle <b>J.</b> Last <b>MC KINNEY</b>		4. DATE OF DEATH Month <b>July</b> Day <b>18</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4-3-1876</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Railroad</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <b>86</b> IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HR
11a. BIRTHPLACE (City and state or country) <b>Polk County, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Charles C. McKinney</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	
14. NAME OF HUSBAND OR WIFE <b>Mary A. McKinney</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>702-03-8738</b>		17. INFORMANT <b>Mrs. Mabel F. Honig, K C Mo.</b> 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) <b>Ventricular fibrillation</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Myocardial infarction</b> DUE TO (c) <b>Coronary Thrombosis.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Generalized arteriosclerosis.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Seconds</b> <b>(?) 12 hr.</b>	
19. WAS AUTOPSY PERFORMED? YES <input 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.)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Pregnant <input type="checkbox"/> No <input type="checkbox"/> Unknown	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		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 <b>June 5, 1962</b> to <b>July 18, 1962</b> last saw him alive on <b>June 18, 1962</b> Death occurred at <b>8:05 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <b>Wm. H. Goodson, Jr. M.D.</b> (Degree or title)	
22b. ADDRESS <b>730 Professional Building Kansas City 6, Mo.</b>		22c. DATE SIGNED <b>7/19/62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>7/20/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Peculiar Cemetery</b>		23d. LOCATION (City, town, or county) <b>Peculiar, Mo.</b>	
24. FUNERAL DIRECTOR <b>Freeman Mortuary</b>		25. DATE RECD. BY LOCAL REG. <b>7-20-62</b>	
26. REGISTRAR'S SIGNATURE <b>Ruth N Long</b>			

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

AUG 14 1962

### 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

*J. H. Freeman*

Licensed Embalmer No. 2939

P. O. Address K. C. Mo.

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.