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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31162**

FILED OCT 12 1945
Registration District No. **274**

Primary Registration District No. **3052**

Registrar's No. **249**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
 (a) County Pettis
 (b) City or town Sedalia
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
City Hospital #2 0
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 7 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Pettis 80
 (c) City or town Sedalia (If outside city or town limits, write "RURAL") 6
 (d) Street No. 616 W. Pettis (If rural, give location) 4
 (e) Citizen of foreign country? No (Yes or No) 0
 If yes, name country _____

3. (a) PRINT FULL NAME Lady Viola Kinney
 3. (b) If veteran, name war none
 3. (c) Social Security No. none
 4. Sex F 3
 5. Color or race Negro
 6. (a) Single, widowed, married, divorced divorced
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive _____ years

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Sept day 25th year 1945 hour 11:30 minute 2 M.
 21. I hereby certify that I attended the deceased from Sept 18 5th 1945 to Sept 25th 1945 that I last saw her alive on Sept 25th 1945 and that death occurred on the date and hour stated above.

7. Birth date of deceased Dec. 27 1891
 (Month) (Day) (Year)
 8. AGE: Years 54 Months 9 Days 28 If less than one day hr. min.

Immediate cause of death Myocardial hemorrhage
apoplexy
 Due to _____
 Due to _____

9. Birthplace Sedalia Mo. 6
 (City, town, or county) (State or foreign country)
 10. Usual occupation Teacher

Other conditions Hemiplegia
 (Include pregnancy within 3 months of death)

MOTHER FATHER
 11. Industry or business C. C. Hubbard High Sch.
 12. Name Patrick K Kinney
 13. Birthplace Unknown 9
 (City, town, or county) (State or foreign country)
 14. Maiden name Little Williams
 15. Birthplace Unknown 0
 (City, town, or county) (State or foreign country)

Major findings:
 Of operations _____
 Of autopsy g30
PHYSICIAN
 Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Cleo Gooch
 (b) Address 701 W COOPER
 17. (a) Burial (b) Date thereof Sept 29-1945
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Crown Hill Annex

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

18. (a) Signature of funeral director [Signature] (Specify type of place)
 (b) Address 400 W. Cooper St (c) Means of injury _____
 19. (a) 9-29-45 (b) A. G. Campbell
 (Date received local registrar) (Registrar's signature)

23. Signature [Signature] (M. P. or other)
 Address Sedalia Mo Date signed 9-25-45

(Licensed Embalmer's Statement on Reverse Side)

1486

10-10-45

APR 1 1948

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed *J. Ryan Alvord*

Licensed Embalmer No. *4245*

P. O. Address. *Sedalia 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 this body is not embalmed, fact should be so stated above.