

JAN 12 1940
Registration District No. **701**

Primary Registration District No. _____

1. PLACE OF DEATH: **1003**
(a) County _____
(b) City or town **St. Louis, Mo.**
(c) Name of hospital or institution:
1763 Mississippi Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME **Charity McKinney 257**
8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Mr. James** 6. (c) Age of husband or wife if alive **75** years
7. Birth date of deceased **March 4 1862**
(Month) (Day) (Year)

8. AGE: Years **77** Months **9** Days **4** If less than one day _____ hr. _____ min.

9. Birthplace **W. Virginia**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER FATHER
12. Name **Charlie Givens**
13. Birthplace **Unknown**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Cora Mae McKinney**
(b) Address **1763 Mississippi**

17. (a) **Removal** (b) Date thereof **12/9/39**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Belle, Mo.**

18. (a) Signature of funeral director **Albert H. Hoppe**
(b) Address **4700 Washington Ave.**

19. (a) **DEC 11 1939** (b) **J. J. [Signature]**
(Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County _____
(c) City or town **Belle** **NR**
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **12** day **8**
year **1939** hour **8** minute **20 A. M.**
21. I hereby certify that I attended the deceased from **Dec. 10th**
_____ 19**39** to **Dec 8th** 19**39**
that I last saw **her** alive on **Dec 7th** 19**39**
and that death occurred on the date and hour stated above.

Immediate cause of death **Lobar Pneumonia** Duration **10 days**

Due to _____
Due to _____

Other conditions **Arterio Sclerosis** **Indefinite**
(Include pregnancy within 3 months of death) PHYSICIAN _____

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

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature **J. J. [Signature]** (M. D. or other) _____
Address **1544 So Broadway** Date signed **12/9-39**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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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 *Albert G. Loppa*

Licensed Embalmer No. *2971*

P. O. Address.....

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 licensc.)

If this body is not embalmed, above space should be left blank.