

Registration District No. 398

Primary Registration District No. 5554

Registrar's No. 104

1. PLACE OF DEATH:
(a) County Jackson Bl. Co. Mo.
(b) City or town Fairmount Station
(c) Name of hospital or institution 10521 East 6th St.
(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

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Fairmount Sta. Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 10521 East 6th St.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years

3. (a) PRINT FULL NAME L'LOUISE McKEE
(b) If veteran, name war None
(c) Social Security No. None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 12
year 1941 hour 10 minute 15 P. M.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married Widowed
6. (b) Name of husband or wife Christopher C. McKee 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Nov. 7 - 1882
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from March, 1941, to April 11, 1941;
that I last saw her alive on April 11, 1941;
and that death occurred on the date and hour stated above.

8. AGE: Years 88 87 ✓ Months 5 Days 5 If less than one day _____ hr. _____ min.

Immediate cause of death Myocardial infarction
Auricular Fibrillation
Bronchial asthma Duration Don't know

9. Birthplace Danville 1 Indiana
(City, town, or county) (State or foreign country)

Due to _____
Due to _____

10. Usual occupation House work

Other conditions Terminal Bronchopneumonia
(Include pregnancy within 3 months of death)

11. Industry or business _____

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

MOTHER FATHER
12. Name Joe Bolen
13. Birthplace 1 Kentucky
(City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace 1 Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Berdine Thomas
(b) Address 10521 East 6th St.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

17. (a) Burial (b) Date thereof Apr. 15-41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mount Washington

(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? 360
(Specify type of place)
While at work? _____ (e) Means of injury _____

18. (a) Signature of funeral director George B. Brown
(b) Address Ind. of Ind.

23. Signature G. Anderson (M. D. or other) MD
Address Ind. Mo Date signed 4-14-41

19. (a) Apr. 15-41 (b) F. L. Cook M.D.
(Date received local registrar) (Registrar's signature)

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

D. Saunders

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 *Lloyd C. Carson*
Licensed Embalmer No. *4199*
P. O. Address *Independence*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 14777

Registration District No. 398

Primary Registration District No. 5554

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Blue Springs
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(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 Louise McKee
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year

7. Birth date of deceased Nov 7 1852
(Month) (Day) (Year)

8. AGE: Years 88 Months 5 Days 5 If less than one day _____ hr _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____ (State or foreign country)

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) June 21 41 (b) F. L. Cook M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 12
year 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h_____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration _____

Due to _____

Due to _____

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

Major findings: _____
Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline
the cause to
which death
should be
charged sta-
tistically.

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 E. D. Saunders (M. D. or other) _____

Address Independence _____

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

SUPPLEMENTARY

