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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

31171

State File No. \_\_\_\_\_

Registration District No. 290

Primary Registration District No. 4431

Registrar's No. 79

1. PLACE OF DEATH:

(a) County Pulaski  
(b) City or town Dixon  
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pulaski 85  
(c) City or town Dixon 1  
(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 \_\_\_\_\_

3. (a) PRINT FULL NAME Sarah McKinnon

3. (b) If veteran, name war \_\_\_\_\_ 3. (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 Franklin, McKinnon 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased June 12, 1857  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
89 2 23 hr. min.

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name Thomas Rigsby 0  
13. Birthplace Missouri  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Franklin McKinnon  
(b) Address Dixon, Mo.

17. (a) Burial (b) Date thereof 9/7/1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Seaton Cemetery

18. (a), Signature of funeral director Fred H. Gilbert

(b) Address Dixon, Mo.

19. (a) 9/14/46 (b) Louise B. McClinton  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 5<sup>th</sup>  
year 1946 hour 5 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from July 29, 1946 to August 26, 1946  
that I last saw her alive on August 15, 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Senility et dementia Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions cell & structures pelvis  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED  
PHYSICIAN \_\_\_\_\_

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) \_\_\_\_\_ 85  
(b) Date of occurrence July  
(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?

(Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_ 2

23. Signature K.W. Milligan (M. D. or other) P.O.  
Address Dixon Mo Date signed 9/13/46

351 (Licensed Embalmer's Statement on Reverse Side)

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

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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. ~~3333~~  
working under my personal supervision.

Signed Fred H. Gillens -

Licensed Embalmer No. 2341

P. O. Address Dixon, 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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. oct  
Registrar's No. 79

Registration District No. 290

Primary Registration District No. F431

1. PLACE OF DEATH: Pulaski  
(a) County.....  
(b) City or town.....  
(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 Israh McKinnion  
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced  
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive.....  
7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years Months Days (If less than one day) hr. min.

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

10. Usual occupation

11. Industry or business

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

16. (a) Informant (b) Address  
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)  
(c) Place: burial or cremation

18. (a) Signature of funeral director (b) Address

19. (a) (Date received local registrar) (b) (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..... year..... hour..... minute..... M.  
21. I hereby certify that I attended the deceased from....., 19.....  
that I last saw him..... alive on....., 19.....  
and that death occurred on the date and hour stated above.  
Immediate cause of death.....

Due to.....  
Due to.....  
Other conditions Fell hurt hip  
(Include pregnancy within 3 months of death)

Major findings: Of operations.....  
Of autopsy.....  
PHYSICIAN  
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) Accident  
(b) Date of occurrence July 29 1946  
(c) Where did injury occur? Dixon Pulaski Mo.  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Fell across chair in home  
While at work? Yes (Specify type of place) (e) Means of injury Chair  
23. Signature R. W. Milligan (M. D. or other) Mo.  
Address Dixon, Mo. Date signed 10/9/46

SUPPLEMENTARY

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