

No. 2  
12-45  
17-39  
X47070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED DEC 31 1946  
Registration District No.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH  
1003

State File No. 38880  
Registrar's No. 10176

Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis, Missouri.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Louis City Hospital—Max C. Starkloff  
(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 \_\_\_\_\_  
(c) City or town ST. LOUIS  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2159A COLLEGE AV.  
Memorial (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 27th  
year 1946 hour 12:10 minute \_\_\_\_\_ P. M.  
21. I hereby certify that I attended the deceased from 11/20/46  
to Nov. 27th 1946  
that I last saw her alive on Nov. 27th 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Cerebral Hemorrhage  
Due to Hypertension  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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)  
Mode of injury \_\_\_\_\_  
Signature Albert H. Maden (M. D.) 11/27/46  
Address 1515 Lafayette Date signed \_\_\_\_\_

3. (a) PRINT FULL NAME SADIE M. KINNEY  
3. (b) If veteran, name war NO  
3. (c) Social Security No. \_\_\_\_\_

4. Sex FEMALE 5. Color or race W.  
6. (a) Single, widowed, married, divorced, WIDOW  
6. (b) Name of husband or wife John C. McKinney  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased JANUARY 29 1877  
(Month) (Day) (Year)

8. AGE: Years 69 Months 9 Days 28  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation NIL

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

MOTHER { 12. Name SAMUEL JENKINS  
13. Birthplace UNKNOWN  
(City, town, or county) (State or foreign country)

MOTHER { 14. Maiden name EMILY UNKNOWN  
15. Birthplace UNKNOWN  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Raymond G. McKinney  
(b) Address 2159<sup>1/2</sup> College

17. (a) BURIAL (b) Date thereof NOV 30-46  
(Burial, cremation, or other) (Month) (Day) (Year)  
(c) Place: burial or cremation Oak Grove Cem.

18. (a) Signature of funeral director E. J. Schuur  
(b) Address 3125 Lafayette Dr.

19. (a) NOV 29 1946 (Date registered)  
J. F. Brebeck (Registrar's signature)

**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

*John B. Volmer*

Licensed Embalmer No.

*4014*

P. O. Address

*St Louis 4 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.**