

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED MAY 15 1957

14372

Registration District No. 314 Primary Registration District No. 6059 Registrar's No. 16

Health,  
Welfare  
Public  
Service

300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

|   |                               |   |   |
|---|-------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>St. Clair</u>   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>St. Clair</u>                |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rural-Collins</u><br>Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |                               | c. CITY OR TOWN <u>Rural-Collins</u> <u>0930</u><br>Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                       |   |
| c. FULL NAME OF (If deceased in hospital, give location) HOSPITAL OR INSTITUTION <u>Washington Twp;</u>   |                               | Length of stay in lb Years <u>Years</u>   |   |
| d. STREET ADDRESS <u>Washington Twp;</u>  |                               | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print) <u>John G. McKinney</u><br>First Middle Last  |                               |   | 4. DATE OF DEATH <u>Apr: 25, 1957</u><br>Month Day Year   |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan; 1, 1879</u>  |
| 9. AGE (In years last birthday) <u>78</u>   |                               | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (City and state or country) <u>South Carolina</u>  |
| 13. FATHER'S NAME <u>Unknown</u>  |                               | 14. MOTHER'S MAIDEN NAME <u>Unknown</u>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>   |                               | 16. SOCIAL SECURITY NO. <u>None</u>   | 17. INFORMANT <u>Bessie McKinney, Collins Missouri</u><br>Address                                       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Suffocation</u><br><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Brush Fire</u><br>DUE TO (c) <u>and smoke</u> |                               |   | INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c). <u>16</u>  |                               |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u> |
| 20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Overcome with heat while burning pasture</u>                |   |
| 20c. TIME OF INJURY <u>5:10</u><br>Hour Month, Day, Year <u>4-25-57</u><br>p. m.  |                               |   |   |
| 20d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                               | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>On farm, home</u>  |   |
|   |                               | 20f. CITY, TOWN, OR LOCATION <u>Collins, Washington Twp, Collins Mo</u><br><u>093</u> COUNTY STATE  |   |
| 21. I attended the deceased from <u>5.10 P</u> to _____ and last saw her/him alive on _____<br>Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.   |                               |   |   |
| 22a. SIGNATURE (Degree or title) <u>Garland B. Gardner Coroner</u>  |                               | 22b. ADDRESS <u>Osceola Mo</u>  |   |
|   |                               | 22c. DATE SIGNED <u>4-26-57</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                               | 23b. DATE <u>4-28-57</u>  |   |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Robinson</u>  |                               | 23d. LOCATION (City, town, or county) <u>Collins Mo</u>   |   |
| 24. FUNERAL DIRECTOR <u>Garland B. Gardner</u><br>ADDRESS <u>Osceola Mo</u>   |                               | 25. DATE RECD. BY LOCAL REG. <u>5/1-57</u>  |   |
|   |                               | 26. REGISTRAR'S SIGNATURE <u>Ruth Seewers</u>   |   |

(Licensed Embalmer's Statement on Reverse Side)

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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 ....., Student Embalmer No. .... working under my personal supervision..

Student .....  
Signature of Student Embalmer

Signed *J. B. [Signature]* .....

Licensed Embalmer No. *3038*

P. O. Address *[Signature]*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.