

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-035225

STATE FILE NUMBER

FILED SEP 30 1958

Registration District No. 381 Primary Registration District No. 4515 Registrar's No. 102

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Sullivan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Sullivan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Milan</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Milan</u> <u>1056</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Al</u> Middle <u>Bert</u> Last <u>McKinstry</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>12</u> Year <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 2, 1888</u>		9. AGE (In years last birthday) <u>69</u> IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Poultry dealer</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Roger, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>

13a. FATHER'S NAME <u>Geo. W. McKinstry</u>		13b. MOTHER'S MAIDEN NAME <u>Isobel Williams</u>		14. NAME OF HUSBAND OR WIFE <u>Icylean Lugeneal (dead)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW I</u>		16. SOCIAL SECURITY NO. <u>509-01-4302-2</u>	17. INFORMANT Address <u>Alta Hudson Milan, Missouri</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial pneumonia</u> Interval between ONSET AND DEATH <u>12 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>491X</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

20a. ACCIDENT <input 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.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	

20e. CITY, TOWN, OR LOCATION <u>Milan, Mo.</u>		COUNTY _____	STATE _____
21. I attended the deceased from <u>9/1/58</u> to <u>9/12/58</u> and last saw her alive on <u>9/12/58</u> Death occurred at <u>3:35</u> a m on the date stated above; and to the best of my knowledge, from the causes stated.		22c. DATE SIGNED <u>9-12-1958</u>	
22a. SIGNATURE <u>V. L. Robinson</u> (Degree or title) <u>D.O.</u>		22b. ADDRESS <u>Milan, Mo.</u>	

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>9/15/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Highland Park Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City, Kansas</u>
24. FUNERAL DIRECTOR <u>Schreyer</u> <u>Dorothy Schreyer</u>		ADDRESS <u>Milan, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>9-15-58</u>
		26. REGISTRAR'S SIGNATURE <u>Mrs. M. W. Beckert</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Secretary, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

SEP

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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 *Dwight Schoene*

Licensed Embalmer No. *2667*

P. O. Address *Milan, Wis.*

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.