

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-008245  
STATE FILE NUMBER

FILED MAR 13 1959

Registration District No. 375 Primary Registration District No. 6279 Registrar's No. 12

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>WRIGHT</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>WRIGHT</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>MANSFIELD</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>MANSFIELD</b> 1140 Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>MANSFIELD 623 DAYS</b> Length of stay in lb		d. STREET ADDRESS (If outside, give location) <b>5 MI EAST RURAL</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED First Middle Last <b>EDWARD FINLEY MCKINLEY</b>			4. DATE OF DEATH Month Day Year <b>3-2-59</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-2-1892</b>
9. AGE (In years last birthday) <b>86</b>		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>	11. BIRTHPLACE (City and state or country) <b>KENTUCKY</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13a. FATHER'S NAME <b>GEORGE MCKINLEY</b>	13b. MOTHER'S MAIDEN NAME <b>MARY HOQUE</b>
14. NAME OF HUSBAND OR WIFE <b>UNKNOWN</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO.
17. INFORMANT Address <b>MANSFIELD HOSPITAL</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypostatic Pneumonia</b> DUE TO (b) <b>Cerebral Hemorrhage</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	
INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Month, Day, Year a.m. p.m.	
20d. INJURY OCCURRED WHILE AT <input 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.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <b>2-27-59</b> to <b>3-2-59</b> and last saw her alive on <b>3-2-59</b> Death occurred at <b>6:20</b> a. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Newton D. Neufeld, D.O.</b>		22b. ADDRESS <b>Mansfield, Missouri</b>	
22c. DATE SIGNED <b>3-5-59</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	
23b. DATE <b>3-4-59</b>		23c. NAME OF CEMETERY OR CREMATORY <b>OAK GROVE</b>	
23d. LOCATION (City, town, or county) <b>WRIGHT</b>		(State) <b>MO.</b>	
24. FUNERAL DIRECTOR <b>Walter A. Simpson</b> ADDRESS <b>Hartsville</b>		25. DATE RECD. BY LOCAL REG. <b>3/10/59</b>	
26. REGISTRAR'S SIGNATURE <b>Bonnie J. Jones</b>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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

8-10-54  
COUNTY HEALTH DEPT.  
COUNTY HEALTH DEPT.

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 *R. U. Barber* .....

Licensed Embalmer No. *3848* .....  
P. O. Address *W. H. Jones* .....

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.