

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-027960

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 1188-A

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

**FILED AUG 14 1963**

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>		c. CITY OR TOWN <b>Springfield,</b>	
Length of stay in 1b <b>47 years</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. John's Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>1347 E. Meadowmere</b>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARY CATHERINE McKINNELL</b>			4. DATE OF DEATH Month Day Year <b>August 5, 1963</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>January 11, 1893</b>
9. AGE (last birthday) <b>70</b>		IF UNDER 1 YEAR Months <b>6</b> Days <b>24</b>	IF UNDER 24 HR Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>In Home</b>	11. BIRTHPLACE (City and state or country) <b>Lamar County, Texas</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>Alexander Gilmore</b>	
13b. MOTHER'S MAIDEN NAME <b>Mary Catherine Speairs</b>		14. NAME OF HUSBAND OR WIFE <b>William P. McKinnell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b></b>	
17. INFORMANT <b>W. Parks McKinnell</b>		Address <b>Springfield, Mo.</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>Cerebral Thrombosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 hours</b>
DUE TO (b) <b>Cerebral arteriosclerosis</b>			<b>&gt; 2 yr</b>
DUE TO (c) <b></b>			<b></b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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. <b></b>	20d. INJURY OCCURRED WHILE AT WORK <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.) <b></b>	20f. CITY, TOWN, OR LOCATION <b></b>
20g. COUNTY <b></b>		20h. STATE <b></b>	
21. I attended the deceased from <b>Sept 1961</b> to <b>Death</b> and last saw her/him alive on <b>8/5/63</b> Death occurred at <b>4:15 A.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Do not write in title) <b>Andrew L. Hahn, M.D.</b>		22b. ADDRESS <b>609 Cherry, Springfield, Mo</b>	22c. DATE SIGNED <b>8-5-63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>August 7, 1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Maple Park</b>	23d. LOCATION (City, town, or county) (State) <b>Springfield, Missouri</b>
24. FUNERAL DIRECTOR <b>Gorman-Scharpf Funeral Home, Inc.</b> Springfield, Missouri		25. DATE RECD. BY LOCAL REG. <b>8-12-63</b>	26. REGISTRAR'S SIGNATURE <b>Bernie Mellay</b>

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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Rev. 4/59

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AUG 14 1963

8/5/63

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 Lewis G. Scharpf

Licensed Embalmer No. 3802

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

Printed Name of Deceased \_\_\_\_\_  
Address of Deceased \_\_\_\_\_  
City and State of Deceased \_\_\_\_\_