

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

30122

Do not use this space.

1. PLACE OF DEATH

County Franklin
Township Fair Grove
City Fair Grove (No. R # 2)

Registration District No. 322
Primary Registration District No. 3446

File No. _____
Registered No. 7 (Ward _____)

2. FULL NAME

(a) Residence. No. Fair Grove, Mo. R # 3 St. _____ Ward _____

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF R. E. Buckner

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 20 - 1879

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
48 1 18

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) N. Carolina

10. NAME OF FATHER

Jerry M. Finnish

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) N. Car.

12. MAIDEN NAME OF MOTHER

Prater

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) N. Carolina

14. INFORMANT

R. E. Buckner
(Address) Fair Grove, Mo.

15. FILED

Oct. 11, 1927 John Klingner
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 8 1927

17. I HEREBY CERTIFY, That I attended deceased from Sept. 25, 1927, to October 3, 1927 that I last saw h.c.r. alive on Oct 3, 1927, and that death occurred, on the date stated above, at 9 A.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocardial Degeneration
43C
130A (duration) 4 yrs. 4 mos. 21 ds.
CONTRIBUTORY (SECONDARY) Nephritis + Arteriosclerosis
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No. DATE OF _____

WHAT TEST CONFIRMED DIAGNOSIS clinical

(Signed) R. E. Rett M.D., M. D.

198, 1927 (Address) Stafford Mo

*State the DISEASE CAUSING DEATH or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Basville Cemetery Oct 9 1927

20. UNDERTAKER

John Klingner & Co. 42 ADDRESS Corral
Springfield, Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

