

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

Do not use this space.

36475 ✓

1. PLACE OF DEATH

County Franklin Registration District No. 297
Towship _____ Primary Registration District No. 301.10
City Washington (No. _____) _____ St. _____ Ward _____

File No. _____
Registered No. 80

2. FULL NAME Rev. Daniel (Stephen) Finckenhofer, O.F.M.

(a) Residence. No. 311 St. Second 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. 1 mos. 9 ds. How long in U.S., if of foreign birth? yrs. _____ mos. _____ ds. _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male | **4. COLOR OR RACE** White | **5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)** Franciscan Priest

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Franciscan Priest

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 22, 1860

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>67</u>	<u>1</u>	<u>20</u>	

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Quincy Illinois
(STATE OR COUNTRY)

10. NAME OF FATHER Caspar Finckenhofer

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Not known
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Catherine Holtgrabe

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Not known
(STATE OR COUNTRY)

14. INFORMANT Dr. Augustin Klassen, O.F.M.
(Address) Washington Mo.

15. Dec 18, 1927 O. L. Munn
REGISTRAR

3

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 12 1927

17. I HEREBY CERTIFY, That I attended deceased from _____
Nov 9, 1927, to Dec 12, 1927.
that I last saw him/her alive on Dec 12, 1927, and that death occurred, on the date stated above, at 7:30 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Influenza
93 C
11 B (duration) _____ yrs. _____ mos. 10 ds.

CONTRIBUTORY (SECONDARY) Cardiac failure
(duration) _____ yrs. _____ mos. 24 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? Missouri, Mo.

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____
20. WAS THERE AN AUTOPSY? No

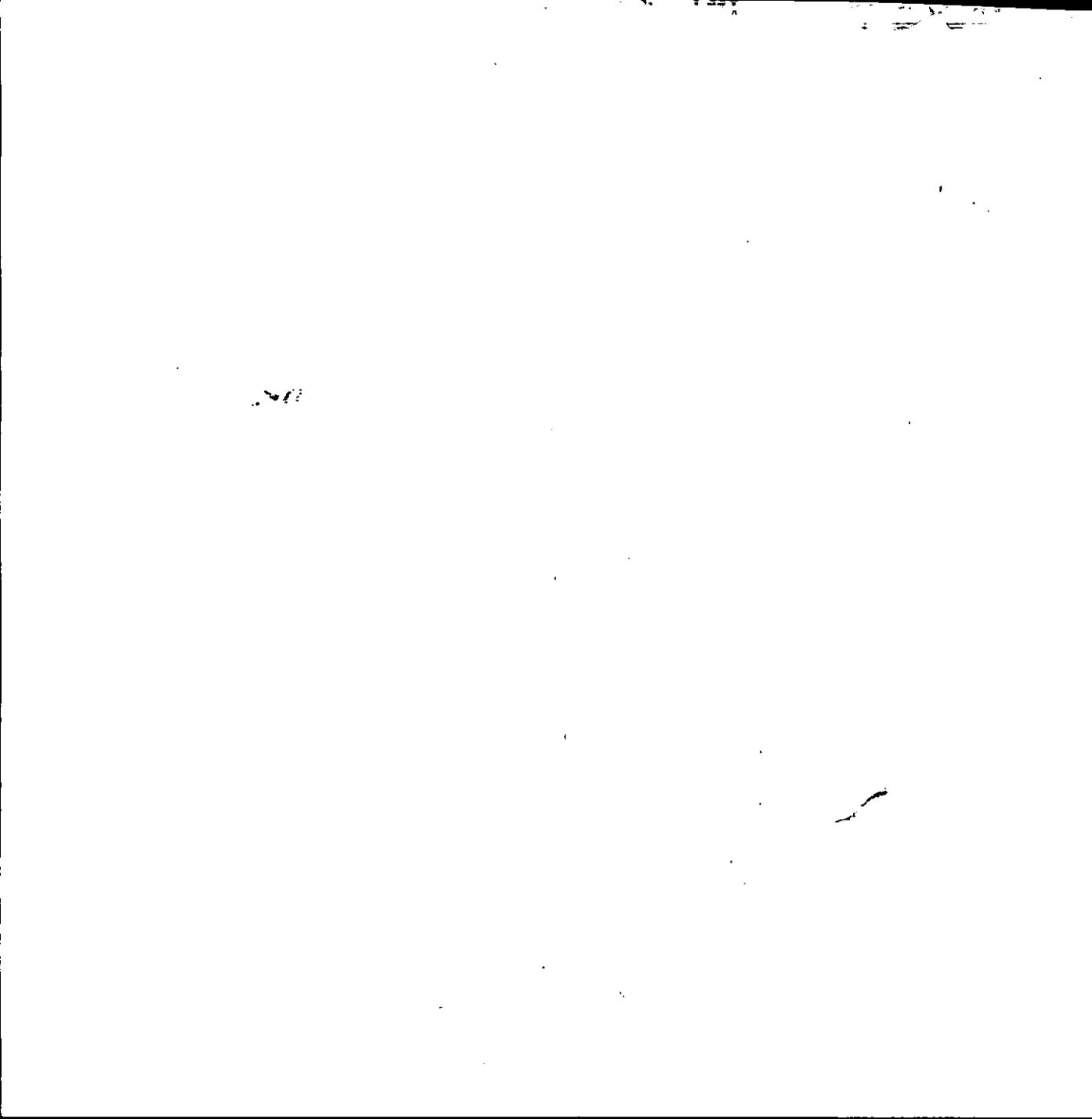
WHAT TEST CONFIRMED DIAGNOSIS? _____
(Signed) Heard G. Mays, M. D.

Dec 12, 1927 (Address) Washington, 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 St. Louis, Mo. **DATE OF BURIAL** Dec 14, 1927

20. UNDERTAKER Otto K. **ADDRESS** Washington, Mo.



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ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Franklin Registration District No. 297 File No. _____
 Township _____ Primary Registration District No. 3016 Registered No. 80
 City Washington (No. _____) St. _____ Ward _____

2. FULL NAME

Rev. Daniel S. Finkenboefer O. F. M.
 (a) Residence No. _____ 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Priest
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. _____
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work _____
 (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) _____
 10. NAME OF FATHER _____
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____
 12. MAIDEN NAME OF MOTHER _____
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

14. INFORMANT (Address) _____
 15. Jan 30 1928 O. L. Munnick REGISTER

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 12 1927
 17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Influenza
Myocarditis Chronic
 CONTRIBUTORY Cardiac Failure
 (SECONDARY) (duration) yrs. mos. ds. _____

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? _____ DATE _____
 WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) J. G. May, M. D.
 _____, 19____ (Address)

*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 _____
 20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

S-36475