

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

Do not use this space.

976

File No. 37
Registered No. _____
St. _____ Ward _____

1. PLACE OF DEATH

County Jackson Registration District No. 398
Township Jordan Primary Registration District No. 4232
City Blue Springs (No. _____) St. _____ Ward _____

2. FULL NAME

Etheldrig John Finnell
(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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 15 -

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
46

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 _____

PARENTS

9. BIRTHPLACE (CITY OR TOWN) Keystone Mo.
(STATE OR COUNTRY) _____
10. NAME OF FATHER Dread Finnell
11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
(STATE OR COUNTRY) _____
12. MAIDEN NAME OF MOTHER Blackship
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY) _____

14. INFORMANT Archa Finnell
(Address) 2963 Jackson St. K 6

15. FILED 3/10, 1930. J.M.G. With REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-22 1930

17. I HEREBY CERTIFY, That Doc. Corwin attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Fractures
Subarachnoid
Skull Fracture, Right Area
in 2 Places (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 210M Saw
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) E. J. Finney, M. D.
1-17-30 (Address) 1111 1/2 W. 1st

*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 Keystone Mo DATE OF BURIAL 1-26 1930

20. UNDERTAKER J.B. Webb Blue Springs ADDRESS _____

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.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
 County Jackson Registration District No. 395 File No. _____
 Township Blue Springs Primary Registration District No. 4232 Registered No. 37
 City _____ St. _____ Ward _____

2. FULL NAME Etheldrig John Linnell
 (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) s

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 10 1884

7. AGE YEARS MONTHS DAYS 46 10 7 1 ^{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) _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jun 22 19 30

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, (That I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Traumatic - Auto accident occurred in Jackson Co. Mo near Own School house last of Spring, Brandt Road
 (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____ IF NOT AT PLACE OF DEATH, _____
 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE (AN AUTOPSY) _____
 WHOSE TEST CONFIRMED DIAGNOSIS? _____ (Signed) _____, M. D.
 _____, 19 (Address) 201

*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.

14. INFORMANT (Address) _____

15. FILED 7/10 1930 F. W. Tuttle REGISTER

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____ 19____

20. UNDERTAKER _____ ADDRESS _____

K. 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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY RECORD

S-976