JUL 25 1930

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

Do not use this space.

18493

1. PLACE OF DEATH

County: Vernon — Registration District No. 875

Township: Washington — Primary Registration District No. 6162

City ..... (No. ..... St. ..... Ward)

File No. .....

Registered No. 132

2. FULL NAME Oren Finley

(a) Residence. No. State Hospital #3 St., Nevada Ward, Mo.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... da. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) D.K. 1881

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	49	DK	DK.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (CITY OR TOWN) Indiana
(STATE OR COUNTY) —

PARENTS

10. NAME OF FATHER Wm Finley

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Rushville
(STATE OR COUNTY) Indiana

12. MAIDEN NAME OF MOTHER Margaret Lawson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) —
(STATE OR COUNTY) Indiana

14. INFORMANT St. Hosp. Record
(Address) Nevada - Mo.

15. FILED 6/17 1930 E. R. King
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 18 1930

17. I HEREBY CERTIFY, That I attended deceased from Feb 8 th, 1926, to May 18 th, 1930, that I last saw h. in alive on May 17 th, 1930, and that death occurred, on the date stated above, at 3 30 am. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Tuberculosis
23A
24

(duration) 4 + yrs. ..... mos. ..... da.

CONTRIBUTORY (SECONDARY) Manic Depressive psychosis —
Chronic Depression (duration) 4 + yrs. ..... mos. ..... da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? No. DATE OF .....
WAS THERE AN AUTOPSY? No.
WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) Staff per FM Grogan, M. D
(Address) State Hosp No. 3 Nevada, Mo. 5/15, 1930

*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: Mulberry Kans — DATE OF BURIAL: 5/20 1930

20. UNDERTAKER: Allen V Hays — ADDRESS: Nevada 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.

Mrs. Lizzie Shelby
Murden Mines
Mo