

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

Do not use this space.

12869

**1. PLACE OF DEATH**

County Stoddard Registration District No. 834  
 Township New Lisbon Primary Registration District No. 6103  
 City (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
 Registered No. 14

**2. FULL NAME**

Geo. Washington Finn  
 (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** Widowed  
(write the word)

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

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)** Dec, 18-1860

**7. AGE**  
 YEARS 70 MONTHS 3 DAYS 6  
If LESS than 1 day, hrs. or min.

**8. OCCUPATION OF DECEASED**  
 (a) Trade, profession, or particular kind of work Farmer 1  
 (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)** Iowa 2

**10. NAME OF FATHER** John Finn

**11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)** Iowa

**12. MAIDEN NAME OF MOTHER** Kraus

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)** Iowa 1

**14. INFORMANT (Address)** Vader Finn Advance No 47

**15. FILED** 5-9, 1931 Cometary REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** Mar 24 1931  
**17.**

I HEREBY CERTIFY That I attended deceased from Mar 22, 1931, to Mar 24, 1931 that I last saw him alive on Mar 23, 1931, and that death occurred, on the date stated above, at 10 p.m.

**THE CAUSE OF DEATH WAS AS FOLLOWS:**  
Pneumonia  
107A 107A  
 (duration) yrs. mos. ds. 16 ds.

**CONTRIBUTORY (SECONDARY)** unknown  
 (duration) yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**  
 IF NOT AT PLACE OF DEATH at place of death

**DID AN OPERATION PRECEDE DEATH?** no DATE OF \_\_\_\_\_

**WAS THERE AN AUTOPSY?** no

**WHAT TEST CONFIRMED DIAGNOSIS?** clinical  
 (Signed) Edward Ford, M. D.  
 , 19 (Address) Boonfield 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** Fagan Cemetery DATE OF BURIAL Mar 25 1931

**20. UNDERTAKER** J. A. Chilee ADDRESS Bloomfield Mo

MAY 27 1931

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.

WHILE LIVING, WITH OBTAINING INK—THIS IS A PERMANENT RECORD

