

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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

*Dr Horst*  
36069  
Do not use this space.

1. PLACE OF DEATH

(a) County GREENE

Registration District No. 318

(b) Township SPRINGFIELD

Primary Registration District No. 2001

Registered No. 757

(c) City SPRINGFIELD

(d) Street No. 512 W. Nichols St.

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

2. PRINT FULL NAME

(a) Residence, No. 512 W Nichols St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 13, 1885

7. AGE YEARS 15 MONTHS 7 DAYS 28 If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife  
9. Industry or business in which work was done, as saw mill, bank, etc. In Home  
10. Date deceased last worked at this occupation. (month and year) 1  
11. Total time (years) spent in this occupation 1

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas

FATHER 13. NAME William H. Sharp

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER 15. MAIDEN NAME Maryl Fito

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT Maryl Finkenbinder (ADDRESS) Springfield, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Memorial Park DATE Oct 13, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Alma Johnson Springfield Mo

20. FILED Oct 13 1939 Chas A. Berger Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 11, 1939

22. I HEREBY CERTIFY, That I attended deceased from Oct. 10, 1939 to Oct 11, 1939

I last saw h. or alive on Oct 11, 1939. Death is said to have occurred on the date stated above, at 11:20 A.M.

The principal cause of death and related causes of importance were as follows:

Cerebral Hemorrhage Date of onset Oct 19, 1939  
Apoplexy

Other contributory causes of importance: None

Name of operation None Date of None

What test confirmed diagnosis Clinical. Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? No Date of injury None, 1939

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) O. C. Horst, M. D.

(Address) 430 South Springfield Mo

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

*Charles C. George*

Registered Apprentice No. *204*

working under my personal supervision.

Signed.....

*Harlow Knabb*

Licensed Embalmer No. *H 065*

P. O. Address *Springfield Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

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