

Registration District No. 963 Primary Registration District No. 0197 Registrar's No. 207

1. PLACE OF DEATH: Moel  
(a) County McDonald  
(b) City or town Moel  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 7  
In this community one year  
years, months or days (Specify whether)

3. (a) PRINT FULL NAME Margaret A. Finney  
3. (b) If veteran, name war. No. 3. (c) Social Security No. 530

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive years (Month) (Day) (Year) May 18<sup>th</sup> 1853

8. AGE: Years 87 Months 21 Days 1 If less than one day hr. min.

9. Birthplace Ill. (City, town, or county) (State or foreign country)

10. Usual occupation 9

11. Industry or business

MOTHER FATHER { 12. Name not known 9  
18. Birthplace Ill. (City, town, or county) (State or foreign country)  
14. Maiden name ++ 14  
15. Birthplace Ill. (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs Eva J. Keager  
(b) Address Moel, McDonald

17. (a) removal (b) Date thereof 465  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation

18. (a) Signature of funeral director M. W. Williams  
(b) Address Southwest, Missouri

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County McDonald  
(c) City or town Moel  
(If outside city or town limits, write "RURAL")  
(d) Street No. (If rural, give location)  
(e) If foreign born, how long in U. S. A? years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 14<sup>th</sup>  
year 1940 hour minute M.  
21. I hereby certify that I attended the deceased from Jan 15,  
1940 to June 14, 1940  
that I last saw her alive on June 13, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Embolism  
Due to Hypertension (Essential)  
Due to Ca. of uterus

Other conditions (Include pregnancy within 3 months of death) 48

Major findings: Of operations 48  
Of autopsy

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify)  
(b) Date of occurrence  
(c) Where did injury occur? (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury  
23. Signature R. E. Varnum (M. D. or other)  
Address Southwest City, Mo. Date signed 6-14-40

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically

WRITE IN INK—USE UNFADING BLACK INK—MAKE 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

I XIBS1

Date Filed \_\_\_\_\_

District File Number \_\_\_\_\_

District Health Officer No. 6,

RECEIVED

District Health Officer No. 6,

District File Number 740-2301

Date Filed JUN 8 1947

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 \_\_\_\_\_

Donald Reed

Registered Apprentice No. 202

working under my personal supervision.

Signed J. B. [Signature]

Licensed Embalmer No. 2689

P. O. Address [Signature]

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **22213**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **963**

Primary Registration District No. **8692**

Registrar's No. \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD—  
MARGARET A. FINNEY

1. PLACE OF DEATH:

(a) County **McDonald**  
(b) City or town **Elk, R. T. P.**  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community \_\_\_\_\_ (Specify whether)  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME

**Margaret A. Finney**

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **14**  
year **1940** hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

4. Sex **F**

5. Color or race **W**

6. (a) Single, widowed, married, divorced **W**

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years **87** Months **-** Days **27** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director **M. E. Williams**

(b) Address **Goodman Mo.**

19. (a) **6-14-1940** (Date received local registrar) (b) **H. C. Alexander** (Registrar's signature)

Duration \_\_\_\_\_  
Immediate cause of death \_\_\_\_\_  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_  
(Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature **W. E. Wynn** (M. D. or other) \_\_\_\_\_  
Address **Southwest City** Date \_\_\_\_\_

SUPPLEMENTARY

