S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SEP 16 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 28571

Registration District No. 318 Primary Registration District No. 5440 Registrar's No. 704

1. PLACE OF DEATH:

(a) County Greene S Campbell

(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Medical Center for Federal Prisoners 3
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 yr. 7 mo. 18 da (Specify whether
In this community 1 yr. 7 mo. 18 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State W. VIRGINIA (b) County Grafton County

(c) City or town Grafton
(If outside city or town limits write "RURAL")

(d) Street No. Unknown
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME FINNIE, James 500

3. (b) If veteran, name war None

3. (c) Social Security No. Unknown

4. Sex Male

5. Color or race Negro

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

6. (b) Name of husband or wife -- ----

6. (c) Age of husband or wife if alive -- years

7. Birth date of deceased June (Month) 13 (Day) 1892 (Year)

8. AGE: Years ✓ 48 Months 2 Days 12 If less than one day ..... hr. ..... min.

9. Birthplace Henry County, Va. (City, town, or county) United States (State or foreign country)

10. Usual occupation Laborer

11. Industry or business Unknown

FATHER
12. Name Silas Finnie
13. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)

MOTHER
14. Maiden name Victoria Baker
15. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)

16. (a) Informant Deceased

(b) Address

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-27-40 (Month) (Day) (Year)

(c) Place: burial or cremation Eastlawn

18. (a) Signature of funeral director Alma Lohmeyer

(b) Address Springfield Mo.

19. (a) Aug 27, 1940 (Date received local registrar) W. E. Handley M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 25th, year 1940 hour 3:00 minute 17 P.M.

21. I hereby certify that I attended the deceased from Jan. 7, 1939 ....., 19..., to Aug. 25, 1940; that I last saw him alive on August 25th, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Endocarditis, Mitral, Thrombosis	since
Pulmonary Arteritis, Right and Left	Adm.
Due to Lung.	
Due to 34	
Other conditions Syphillis, Tertiary (Include pregnancy within 3 months of death)	

Major findings:
Of operations

Of autopsy Yes
Diagnosis verified by Clinical, records

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? No (e) Means of injury

23. Signature L. M. Rogers M.D. (M. D. or other)
Address Clinical Director MCFP Date signed

(Licensed Embalmer's Statement on Reverse Side)

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Harlow Knabb

Licensed Embalmer No. 4065

P. O. Address Springfield Mo

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

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