

Registration District No. **853**

Primary Registration District No. **6117**

Registrar's No. **11**

1. PLACE OF DEATH

(a) County **Sullivan**
(b) City or town **Rural - Liberty Twp.**
(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 **2**
In this community **66 years**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Sullivan**
(c) City or town **Rural**
(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 **Marg L. Fincham**

3. (b) If veteran, name war **L** 3. (c) Social Security No. **none**

4. Sex **Female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Samuel Fincham** 6. (c) Age of husband or wife if alive **68** years

7. Birth date of deceased **Jan 13 1874**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	66	8	6	hr. min.

9. Birthplace **Sullivan** **1116 0**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmers wife** **1**

11. Industry or business **House work** **1**

12. Name **John R. Ross**

13. Birthplace **Pa.**
(City, town, or county) (State or foreign country)

14. Maiden name **Elizabeth McClaskey**

15. Birthplace **Sullivan Co** **116**
(City, town, or county) (State or foreign country)

16. (a) Informant **Samuel Fincham**

(b) Address **Milan Mo**

17. (a) **Burial** (b) Date thereof **Sept 21, 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Agony Cem.**

18. (a) Signature of funeral director **Schoener**
(b) Address **Milan, Missouri**

19. (a) **Oct. 4, 1940** (b) **Mrs. Ruth Tucker**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **19**
year **1940** hour **3** minute **30** P.M.

21. I hereby certify that I attended the deceased from **July 9th**
1940 to **Sept 19th** **1940**
that I last saw her alive on **Sept 19th** **1940**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage** **9 days**
Duration

Due to **Arteriosclerosis with Chronic Nephritis** **10 3/4**
Due to

Other conditions (Include pregnancy within 3 months of death) **31**

Major findings: Of operations **31** Of autopsy _____
PHYSICIAN _____
Underlying 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? **7108**

(e) While at work? _____ (Specify type of place) (e) Means of injury **3**

23. Signature **L. Grace Simmons** (M. D. or other) **D.O.**
Address **Milan, Mo.** Date signed **9/20/40**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

5

RECEIVED

District Health Officer No. 10

District File Number 10-40-1872

Date Filed OCT 8 1940

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

Frank D. Schone

Registered Apprentice No.

working under my personal supervision.

Signed *Frank D. Schone*

Licensed Embalmer No. 2916

P. O. Address *Man, N*

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.