

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

41926

State File No. _____

Registration District No. **85**

Primary Registration District No. **1001**

Registrar's No. **1373**

1. PLACE OF DEATH:

(a) County **Buchanan**
(b) City or town **St. Joseph**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **309 Indiana**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **11 years**
In this community **Life time** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Margaret Emeline Finch**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**
4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **George** 6. (c) Age of husband or wife if alive **years**

7. Birth date of deceased **November 2, 1864 Missouri**
(Month) (Day) (Year)

8. AGE: Years **76** Months **1** Days **27** If less than one day hr. min.

9. Birthplace **Buchanan County, Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business **Home**

12. Name **John Dittmore**

13. Birthplace **Buchanan County Missouri**
(City, town, or county) (State or foreign country)

14. Maiden name **Parsons**

15. Birthplace **Kansas**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Alma Wier (Daughter)**

(b) Address **309 Indiana**

17. (a) **Burial** (b) Date thereof **Dec. 31, 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Bethel Cemetery**

18. (a) Signature of funeral director **John E. Rupp**

(b) Address **6054 Pryor Ave.**

19. (a) **Dec 31 - 1940** (b) **J. S. Heston**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Buchanan**
(c) City or town **St. Joseph**
(If outside city or town limits, write "RURAL")
(d) Street No. **309 Indiana**
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **29**
year **40** hour **8** minute **40 A.M.**

21. I hereby certify that I attended the deceased from **Dec 28** to **Dec 28**, 19**40**
that I last saw him **alive on Dec 28**, 19**40**
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary disease** Duration **1 hr**

Due to **Myocardial thrombosis** **1 hr**

Due to _____

Other conditions **92 C**
(Include pregnancy within 3 months of death)

Major findings: **Of operations**

Of autopsy _____

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? **85**
While at work _____ (Specify type of place) (e) Means of injury _____

23. Signature **J. S. Heston** (M. D. or other) **1**
Address **St. Joseph** Date signed **12-31-40**

D. Allaman
Central Bldg

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.....

Myself

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

working under my personal supervision.

Signed

John E. Ruff

Licensed Embalmer No. 3988

P. O. Address 6054 Pryor Ave. St. Jose

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, fact should be so stated above.