

FILLED JUL 19 1941

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **22852**

Registration District No. **802**

Primary Registration District No. **6046**

Registrar's No. **82**

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

1. PLACE OF DEATH:

(a) County **Schuyler**

(b) City or town **Rural - Lancaster - Fabius** State **Mo**

(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 **75** years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) County **Schuyler** State **Mo**

(b) City or town **Rural - Lancaster** (If outside city or town limits, write "RURAL")

(c) Street No. _____ (If rural, give location) **0**

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

8. (a) PRINT FULL NAME **Greenberry Franklin Fincher**

8. (b) If veteran, name war No. _____

3. (c) Social Security No. **1**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **21** year **1941** hour **8** minute _____ P. M.

21. I hereby certify that I attended the deceased from **Jan 1** 1941, to **Feb. 11** 1941 that I last saw him alive on _____ 19____ and that death occurred on the date and hour stated above.

4. Sex **Male** 5. Color or race **White**

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

6. (b) Name of husband or wife **Belle Gora Fincher** 6. (c) Age of husband or wife if alive **75** years

7. Birth date of deceased **May 16 1866** (Month) (Day) (Year)

Immediate cause of death _____

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

Major findings: Of operations _____

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? **791** (Specify type of place)

While at work? _____ (e) Means of injury _____

8. AGE: Years **75** Months **1** Days **5** If less than one day _____ hr. _____ min.

9. Birthplace **Schuyler Mo. Mo.** (City, town, or county) (State or foreign country)

10. Usual occupation **farmer**

11. Industry or business _____

12. Name **John Fincher**

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

14. Maiden name **Lucinda Hicks**

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

16. (a) Informant **Mr. Nora Gray**

(b) Address **Lancaster Mo**

17. (a) **Burial** (b) Date thereof **June 23 41** (Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of general director **Marehead's**

(b) Address **Lancaster Mo**

19. (a) **June 24 - 41** (b) **J. E. Crawshaw** (Date received local registrar) (Registrar's signature)

Due to **Paralysis of Arteries of Brights**

Due to **discharge**

23. Signature **J. E. Crawshaw** (M. D. or other) **6/24/41**

Address **Lancaster Mo** Date signed _____

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RECEIVED

District Health Officer No. 10

District File Number 7-41-1303

Date Filed JUL 16 1941

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.....

True & Minnie Morehead

Registered Apprentice No.

working under my personal supervision.

Signed Morehead's

Licensed Embalmer No. 3731-3680

P. O. Address Leicester 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 22852
Registrar's No. 82

Registration District No. 802

Primary Registration District No. 6046

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

1. PLACE OF DEATH:

(a) County Schuyler
(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)
(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 _____
years, months or days)

3. (a) PRINT FULL NAME Greenberry J Fincher
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w
6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year _____
7. Birth date of deceased _____
(Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) June 24 (b) 41
(Date received local registrar) (Registrar's signature)

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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 21
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; to _____, 19____;
that I last saw him alive on Feb 11, 1941
and that death occurred on the date and hour stated above.
Immediate cause of death _____ Duration _____

Due to Paralysis and Chronic Bright's Disease
Due to Cerebral Hemorrhage

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

Major findings: _____
Of operations _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTAL

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-22852