

FILED OCT 13 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 30650  
3407  
Registrar's No.

Registration District No. 377

Primary Registration District No. 102

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

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Joseph Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 10 hrs (Specify whether  
In this community 10 hrs years, months or days)

3. (a) PRINT FULL NAME Infant Finks

3. (b) If veteran, name war --- 3. (c) Social Security No. no

4. Sex Female 5. Color or race White 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: September 11, 1941  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
0 0 0 10 hr. min.

9. Birthplace: Kansas City, Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation -----

11. Industry or business none

12. Name Charles P. Finks  
13. Birthplace Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Eva M. Bybee  
15. Birthplace Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Charles P. Finks  
(b) Address 1117 East 45th Street

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-12-1941  
(Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill Freeman Mortuary

18. (a) Signature of funeral director -----  
(b) Address Kansas City, Missouri

19. (a) 9/12/41 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1117 E. 45th Street  
(If rural, give location)  
(e) Citizen of foreign country? J (Yes or No)  
If yes, name country -----

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 11 year 1941 hour 10 minute 0 A. M.

21. I hereby certify that I attended the deceased from 9/11/41 to 9/11/41 1941;  
that I last saw her alive on 9/11 1941;  
and that death occurred on the date and hour stated above.

Immediate cause of death Placental Duration -----

Due to permativity

Due to ---

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

Major findings: Of operations ---

Of autopsy atletics

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? ---

While at work? (Specify type of place) (e) Means of injury ---

23. Signature Harold Hamilton (M. D. or other) MD  
Address 1102 Bryant Bldg Date signed 9/11/41

**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 Clarence Chiles  
Licensed Embalmer No. 3473  
P. O. Address 76 e 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, fact should be so stated above.**