

DEPARTMENT OF COMMERCE

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 2583

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 2583

1. PLACE OF DEATH: Jackson  
 (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: K.C. General Hospital No. 1  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 10 days (Specify whether  
 In this community unk years, months or days)

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. 1000 E. 8th St. (If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME George Finney  
 3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Widower  
 6. (b) Name of husband or wife unk 6. (c) Age of husband or wife if alive unk years  
 7. Birth date of deceased Dec. 29<sup>th</sup> 1881 (Month) (Day) (Year)

8. AGE: Years 60 Months 6 Days 5 If less than one day hr. min.

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

10. Usual occupation Janitor

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name George Finney  
 13. Birthplace England (City, town, or county) (State or foreign country)  
 14. Maiden name Ida Hannawalt  
 15. Birthplace Iowa (City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk  
 (b) Address K.C. General Hospital

17. (a) Burial (b) Date thereof 7-8-42 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Rede

18. (a) Signature of funeral director Wm. A. Johnson  
 (b) Address City of Mortician  
 19. (a) 7-7-42 (b) M. M. Crowe (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 4th year 1942 hour 7 minute 30 A.M. M.

21. I hereby certify that I attended the deceased from 6-24-42, 1942, to 7-4-42, 1942; that I last saw him alive on 7-4-42, 1942; and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac decompensation  
 Due to 95°  
 Due to \_\_\_\_\_  
 Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
 Major findings: Of operations \_\_\_\_\_  
 Of autopsy None

Duration \_\_\_\_\_  
 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? \_\_\_\_\_

23. Signature Drury K. Thom (Specify type of glycer) (M. D. or other)  
 Address Med. Dir. K.C. Gen. Hospital K.C. Mo. Date signed 7-7-42

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

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**