

S. No. 2
M-5-42
S-17-39
I X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **2230**

FILED FEB 5 1943

Registration District No. **130**

Primary Registration District No. **54634**

Registrar's No. **13**

1. PLACE OF DEATH:

(a) County **Greene**

(b) City or town **Rural - S. Jackson Township**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **X /**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **X** (Specify whether **life**)
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Greene**

(c) City or town **Rural**
(If outside city or town limits, write "RURAL")

(d) Street No. **S. Jackson Township**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **X**

3. (a) PRINT FULL NAME **Jane Finch**

3. (b) If veteran, name war **X**

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **21**
year **1942** hour **11** minute **P.** M.

21. I hereby certify that I attended the deceased from **Dec. 13** 19 **42** to **Dec. 19** 19 **42**
that I last saw her alive on **Dec. 15** 19 **42**
and that death occurred on the date and hour stated above.

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

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

6. (b) Name of husband or wife **Finch**

6. (c) Age of husband or wife if alive **X** years

7. Birth date of deceased **September 4 - 1864**
(Month) (Day) (Year)

Immediate cause of death

Chronic Nephritis ?

Arterial Sclerosis ?

Due to

Due to

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations **131 f**

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

8. AGE: Years **78** Months **3** Days **17**
If less than one day **X** hr. **X** min.

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

10. Usual occupation **Housewife**

11. Industry or business **Home**

MOTHER FATHER 12. Name **Robert McGehee**

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

14. Maiden name **Kirkins**

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

16. (a) Informant **Mrs. Mae Dishman (day)**

(b) Address **Strafford, Mo.**

17. (a) **Burial** (b) Date thereof **Cedar Bluff**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Cedar Bluff**

18. (a) Signature of funeral director **Wm. J. Jolley**

(b) Address **Marshallfield, Mo.**

19. (a) **Jan 5, 1943** (b) **Barclay Harmon**
(Date received local registrar) (Registrar's signature)

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) (Type of means of injury)

23. Signature **G. H. Focht** (M. D. or other) **ML**
Address **Strafford Mo** Date signed **1/5/43**

1-2 46 (Licensed Embalmer's Statement on Reverse Side)

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

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. _____

3312

P. O. Address _____

Marshfield, 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.