No. 2
—5-42
6-17-39
15M
X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

8019

State File No.

D MAR 12 1943 378

Registration District No.

Primary Registration District No. 6785

Registrar's No.

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

1. PLACE OF DEATH
(a) County: Wright
(b) City or town: Mtn Grove Twp
(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 years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mtn Grove (b) County: Wright
(c) City or town: Missouri
(If outside city or town limits, write "RURAL")
(d) Street No.: rural
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: 0

3. (a) PRINT FULL NAME: Wilson Julius Finch

3. (b) If veteran, name war:

3. (c) Social Security No.:

4. Sex: Male

5. Color or race: White

6. (a) Single, widowed, married, divorced: 0

6. (b) Name of husband or wife:

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

7. Birth date of deceased: July (Month) 5th (Day) 1942 (Year)

8. AGE: Years | Months: 7 | Days: 19 | If less than one day: hr. min.

9. Birthplace: Norwood (City, town, or county) Mo. (State or foreign country)

10. Usual occupation: Baby

11. Industry or business:

MOTHER FATHER

12. Name: James Finch

13. Birthplace: Mo. (City, town, or county) 0 (State or foreign country)

14. Maiden name: Minnie May Akenman

15. Birthplace: Mo. (City, town, or county) 0 (State or foreign country)

16. (a) Informant: Father - James Finch
(b) Address: Mtn. Grove, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb. 25 1943 (Month) (Day) (Year)
(c) Place: burial or cremation: Norwood

18. (a) Signature of funeral director: Russell Barber
(b) Address: Mtn Grove, Mo

19. (a) 3/8-43 (Date received local registrar) (b) H. M. Lower (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 24 year 1943 hour minute M.

21. I hereby certify that I attended the deceased from Feb. 24 — 1943 to Feb. 24 — 1943 that I last saw him alive on Feb. 24 — 1943 and that death occurred on the date and hour stated above.

Immediate cause of death: Bronchial Pneumonia

Duration

Due to:

Due to:

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

Major findings:
Of operations:

Of autopsy:

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

23. Signature: R W Flynn (M. D. or other)
Address: Mtn. Grove Mo. Date signed 3-8-43

1333 (Licensed Embalmer's Statement on Reverse Side)

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.

S. No. 2B
M—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 80 19

Registration District No. ..... Primary Registration District No. ..... Registrar's No. .....

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

1. PLACE OF DEATH:

(a) County: Wright

(b) City or town: Mtn Grove
(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 years, months or days)
In this community .....

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Wright

(c) City or town: Mtn Grove
(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 .....

3. (a) PRINT FULL NAME: Wilson J. Finch

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: S

6. (b) Name of husband or wife ..... 6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased: July (Month) 5 (Day) 1874 (Year)

8. AGE: Years — Months 7 Days ..... If less than one day: ..... hr. ..... min.

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

10. Usual occupation .....

11. Industry or business .....

MOTHER FATHER

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) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....

18. (a) Signature of funeral director .....
(b) Address .....

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. Day 24 year 1943 hour ..... minute ..... M.

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

Immediate cause of death: Bronchial Pneumonia — Duration

Due to: No Complications

Due to: .....

Other conditions (Include pregnancy within 3 months of death): 107

Major findings:
Of operations .....
Of autopsy .....

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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? ..... (Specify type of place)
While at work? ..... (c) Means of injury .....

23. Signature: R. N. Flenny (M. D. or other)
Address: Mtn Grove Mo. Date signed .....

SUPPLEMENTARY