

Registration District No. 114

Primary Registration District No. 4186

Registrar's No. 10

**1. PLACE OF DEATH:**

(a) County FRANKLIN  
 (b) City or town SULLIVAN MO  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: NORTHSIDE HOSPITAL  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 7 days  
 (Specify whether years, months or days) 78 years

3. (a) PRINT FULL NAME MARY EULINA FINNEY

3. (b) If veteran, name war U 3. (c) Social Security No. \_\_\_\_\_

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, 2 divorced WIDOWED

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

7. Birth date of deceased April 12 66  
 (Month) (Day) (Year)

8. AGE: Years 78 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Franklin Co - MO-O  
 (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business None

12. Name Walter Thurmond

13. Birthplace MO-O  
 (City, town, or county) (State or foreign country)

14. Maiden name Sherida Steel

15. Birthplace MO-O  
 (City, town, or county) (State or foreign country)

16. (a) Informant: Fred Finney

(b) Address Sullivan Mo

17. (a) Burial (b) Date thereof April 14 44  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cape Spring, Mo

18. (a) Signature of funeral director Walter Thurmond

(b) Address Sullivan Mo

19. (a) 4-13-44 (b) Gilbert Wilkerson  
 (Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Franklin  
 (c) City or town Sullivan Rural  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) If foreign born, how long in U. S. A? Years

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month April day 11  
 year 1944 hour 1:15 minute P. M.

21. I hereby certify that I attended the deceased from 4-10 1944 to 4-11 1944  
 that I last saw her alive on 4-11 1944  
 and that death occurred on the date and hour stated above.

Immediate cause of death Congestive heart failure  
 Due to Chronic Coronerular Nephritis  
 Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
 Major findings: Of operations 131 P  
 Of autopsy \_\_\_\_\_

Duration

unknown

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 D. P. Garner (M., D. or other) D.O.  
 Address Sullivan Mo Date signed 4-13-44

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

RECEIVED

District Health Officer No. 9,

District File Number \_\_\_\_\_

Date Filed 5-15-44

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 Edgaw W. Sullivan

Licensed Embalmer No. 33914

P. O. Address Sullivan Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.