

FILED OCT 13 1944

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

31937

State File No.

Registration District No. 359

Primary Registration District No. 6221

Registrar's No. 19

1. PLACE OF DEATH:

(a) County Deerbon  
(b) City or town Monticello Township  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location) 1  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 50 years (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME Finley Bartholomew Hale

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, Widowed

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

7. Birth date of deceased Jan 4 1861  
(Month) (Day) (Year)

8. AGE: Years 83 Months 8 Days 15 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation farmer

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

12. Name Finley B. Hale

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

14. Maiden name unknown

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

16. (a) Informant Mrs. Bill Hale

(b) Address Shelton Mo.

17. (a) Burial (b) Date thereof Sept 21-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Prayer Cemetery

18. (a) Signature of funeral director H. B. Green & Sons

(b) Address Shelton Mo.

19. (a) Sept 30 44 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Deerbon  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9-18-44 day \_\_\_\_\_  
year 1944 minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 9-10-44  
19 \_\_\_\_\_ to 9-18-44  
that I last saw him alive on 9-18-44 19 \_\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to Cerebral Hemorrhage

Due to Myocarditis & Hypertension

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 [Signature] (M. D. or other) \_\_\_\_\_

Address [Signature] Date signed 9-28-44

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

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

RECEIVED

By \_\_\_\_\_ Officer No. 7,

\_\_\_\_\_ 9-44-1185

Date Filed \_\_\_\_\_ 10-12-44

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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..... *Carroll T. Beery*.....

Licensed Embalmer No..... *7385*.....

P. O. Address..... *Sheldon 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.**