

Registration District No. 333

Primary Registration District No. 3094

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Scott
(b) City or town Rural
(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)
In this community 1 yr
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Scott
(c) City or town Rural 180
(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 _____

3. (a) PRINT FULL NAME

ADA FINLEY

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife George 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Aug 18 1879
(Month) (Day) (Year)

8. AGE: Years 65 Months 6 Days 26 If less than one day hr. _____ min. _____

9. Birthplace Fulton Co Ark 1
(City, town, or county) (State or foreign country)

10. Usual occupation at home

MOTHER FATHER
11. Industry or business _____

12. Name James Cox
13. Birthplace Baxter Co Ark 1
(City, town, or county) (State or foreign country)
14. Maiden name Anna Clinkensbeard
15. Birthplace Baxter Co Ark 1
(City, town, or county) (State or foreign country)

16. (a) Informant George Finley
(b) Address Sikeston Mo
17. (a) removal (b) Date thereof 2-14-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mountain Home, Ark.
18. (a) Signature of funeral director Welsh Funeral Home
(b) Address Sikeston Mo

19. (a) 3/14/45 (b) Louis Largent
(Date received by local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 14
year 1945 hour 6:40 minute 1 M.

21. I hereby certify that I attended the deceased from Feb. 13 1945
_____, 19____, to Feb 13, 19____
that I last saw her alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death PNEUMONIA
Due to Renal Dropsy
Due to _____

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations 12211
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? _____

While at work? _____ (Specify type of place) (b) Means of injury _____
23. Signature J. L. D. D. D. D. D. (M. D. or other)
Address Sikeston Mo Date signed 2-14-45

RECEIVED

District Health Office

District File Number 345

Date Filed 3/1

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 Raymond J. Crews

Licensed Embalmer No. 3467

P. O. Address Sikeston, 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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 333

Primary Registration District No. 16151

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Scott
(b) City or town Rural Richland
(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 _____)

In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME

Ada Finley

(b) If veteran, name war _____

(c) Social Security No. _____

4. Sex F 5. Color of race W 6. (a) Single, widowed, married, divorced M

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

7. Birth date of deceased Aug 18
(Month) (Day) (Year)

8. AGE: Years 65 Months 6 Days _____ If less than one day _____ min.

9. Birthplace _____ (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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day _____
year 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;

that I last saw him/her alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death _____

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? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

10771