

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

FILED NOV 16 1945 STANDARD CERTIFICATE OF DEATH

State File No. 37814

Registration District No. 184

Primary Registration District No. 3038

Registrar's No. 593

1. PLACE OF DEATH:

(a) County Linn
(b) City or town BROOKFIELD
(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 18 yrs. (Specify whether years, months or days)
In this community

3. (a) PRINT FULL NAME CHLOE A E McFINNEY
3. (b) If veteran, name war - 3. (c) Social Security No. -

4. Sex 7. m 5. Color or race white 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife - 6. (c) Age of husband or wife if alive 6 years
7. Birth date of deceased April 6 1868
(Month) (Day) (Year)

8. AGE: Years 77 Months 6 Days 9 If less than one day hr. min.

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

10. Usual occupation Housekeeping at home

11. Industry or business at home

12. Name Charles Earl

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

14. Maiden name Rachel - unknown

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

16. (a) Informant 9 yrs. Sarah
(b) Address Brookfield Mo.

17. (a) Burial (b) Date thereof Oct. 17, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Boston, Mo.

18. (a) Signature of funeral director James F. Taylor
(b) Address Brookfield Mo.

19. (a) 10-16-45 (b) Emily Kelley
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Linn 58
(c) City or town Brookfield 2
(If outside city or town limits, write "RURAL")
(d) Street No. 1019 N. Main
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 15, year 1945 hour 11 minute 40 A.M.

21. I hereby certify that I attended the deceased from Mar 10 1937 to Oct 13 1945
that I last saw him alive on Oct 13 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage 5 mo
Due to General arteriosclerosis 10 yrs.

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations § 30

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?

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

23. Signature Ray R. Stala (M. D. or other) mo

Address Brookfield Mo. Date signed 10/16/45

(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.....

E. A. Larson

Licensed Embalmer No. *4037*

P. O. Address.....

Bucklin, 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.