

S. No. 2
M-5-43
5-17-39
P I X36871

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 17 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **39659**
Registrar's No. **1367**

Registration District No. **42** Primary Registration District No. **1000**

1. PLACE OF DEATH:
(a) County **Buchanan**
(b) City or town **St. Joseph**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1120 Main Street
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **Not** (Specify whether)
In this community **1 Years** (years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Buchanan**
(c) City or town **St. Joseph**
(If outside city or town limits, write "RURAL")
(d) Street No. **1120 Main Street**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **Ella M. Finney**
3. (b) If veteran, name war **No** 3. (c) Social Security No. **None**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **December** day **4th** year **1946** hour **4:50** minute **P.** M.

4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Divorced**
6. (b) Name of husband or wife **R. V. Fullerton** 6. (c) Age of husband or wife if alive **5** years
7. Birth date of deceased **August 5 1870**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Dec 1 1946** to **Dec 4 1946**
that I last saw her alive on **Dec 4 1946**
and that death occurred on the date and hour stated above.

8. AGE: Years **76** Months **3** Days **29** If less than one day hr. min.

Immediate cause of death **Atherosclerosis general**
Cerebral hemorrhage - left (Left Hemiplegia)
Due to **12-1-46**

9. Birthplace **Waterville - Kansas**
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death)
Due to

10. Usual occupation **None**

Major findings: **g 30 A**
Of operations
Of autopsy
PHYSICIAN
Underline the cause to which death should be charged statistically.

11. Industry or business

MOTHER FATHER
12. Name **Esquire D. Finney**
13. Birthplace **Troy New York**
(City, town, or county) (State or foreign country)
14. Maiden name **Julia B. Bosley**
15. Birthplace **Columbus Ohio**
(City, town, or county) (State or foreign country)

16. (a) Informant **Self**
(b) Address **1120 Main St., St. Joseph, Missouri.**

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?

17. (a) **Removal** (b) Date thereof **12/7/1946**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Graham, Missouri.**
18. (a) Signature of funeral director **Walter Meierhoffer**
(b) Address **1302 Faraon, St. Joseph, Missouri**

(Specify type of place)
While at work? (e) Means of injury
19. (a) **Dec. 11, 1946** (b) **E. C. Johnson by J. man**
(Date received local registrar) (Registrar's signature) (Address) **St. Joseph, Mo** Date signed **12-5-46**

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..... *Albert C. Harrington*.....
Licensed Embalmer No..... *3288* Missouri.....
P. O. Address..... *St. Joseph, Missouri*.....

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.