FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

31192

State File No.

FILED OCT 11 1947

Registration District No. 1009

Primary Registration District No. 1002

Registrar's No. 4154

1. PLACE OF DEATH:
(a) County: JACKSON
(b) City or town: KANSAS CITY
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: GENERAL HOSPITAL NO. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 1 DAY (Specify whether years, months or days)
In this community: 24 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State: MISSOURI (b) County: JACKSON
(c) City or town: KANSAS CITY
(If outside city or town limits, write "RURAL")
(d) Street No.: 1120 E. 18TH ST.
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: CHARLEY FINNEY
3. (b) If veteran, name war: No
3. (c) Social Security No.: 493-12-8135

4. Sex: MALE
5. Color or race: NEGRO
6. (a) Single, widowed, married, divorced: Single
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: NOVEMBER (Month) 18 (Day) 1874 (Year)

8. AGE: Years 72 Months 10 Days 9 If less than one day hr. min.

9. Birthplace: SHELDY (City, town, or county) MISSISSIPPI (State or foreign country)
10. Usual occupation: NONE
11. Industry or business:
FATHER 12. Name: ALBERT FINNEY
13. Birthplace: UNKNOWN (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name: ELIZA
15. Birthplace: UNKNOWN (City, town, or county) (State or foreign country)
16. (a) Informant: ARCHIE SMITH (FRIEND)
(b) Address: 2525 VINE STREET
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: OCT 3 1947 (Month) (Day) (Year)
(c) Place: burial or cremation: Lincoln Cem.
18. (a) Signature of funeral director: C.B. Davis
(b) Address: 1513 Troost Ave.
19. (a) 10-2-47 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPTEMBER day 27, year 1947 hour 1: minute 18 A. M.
21. I hereby certify that I attended the deceased from SEPTEMBER 26, 1947 to SEPTEMBER 27, 1947 that I last saw him alive on SEPTEMBER 27, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: GANGRENE OF BOTH LUNGS	
Due to: LUNG ABSCESS (nont. B.) (etiology undetermined)	
Due to:	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations: 114C
Of autopsy:

PHYSICIAN — Underline the cause of 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? (Specify type of place)
While at work: (e) Means of injury:

23. Signature: [illegible] (M. D. or other) M.D.
Address: GENERAL HOSPITAL NO. 2 Date signed: 9/27/47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 C. E. Davis

Licensed Embalmer No. 4417

P. O. Address N. C. 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.