

FILED FEB 5 1948

Registration District No. **343**

Primary Registration District No. **6156**

Registrar's No. \_\_\_\_\_

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

**1. PLACE OF DEATH:**

(a) County Stutard  
(b) City or town Essary Mo  
(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 \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME EMMETT FINLEY

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Finley 6. (c) Age of husband or wife if alive 47 years

7. Birth date of deceased April 6 1895  
(Month) (Day) (Year)

| 8. AGE: | Years     | Months   | Days      | If less than one day |
|---------|-----------|----------|-----------|----------------------|
|         | <u>52</u> | <u>8</u> | <u>29</u> | _____ hr. _____ min. |

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

10. Usual occupation farmer

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

MOTHER FATHER

12. Name W. W. Finley

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

14. Maiden name Anna Sapp

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

16. (a) Informant Maie Finley

(b) Address Essary Mo 802

17. (a) \_\_\_\_\_ (b) Date thereof 1-7-1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bloomington

18. (a) Signature of funeral director W. T. Emmerich

(b) Address St. Joseph Mo

19. (a) Jan 28 (b) Mrs Kate Finley  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County Stutard  
(c) City or town Essary  
(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 Jan day 5  
year 1948 hour 7 minute 15 P.M.

21. I hereby certify that I attended the deceased from Jan 20 1947 to Jan 3 1948  
that I last saw him alive on Jan 3 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Asthma

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? 2

(e) Signature D. G. Cannon (Specify type of place) (f) Means of injury \_\_\_\_\_

23. Signature D. G. Cannon (M.D. or other) \_\_\_\_\_  
Address Essary Date signed 1/6/48

RECEIVED

District Health Office No. 2,

District No. 248-120

Date Filed 8-2-48

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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.....

Licensed Embalmer No.....

P. O. Address.....

**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.