

S. No. 300
DM-10-47
Rev. 5-17-39
I 3906

FEDERAL SECURITY AGENCY
- National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **40117**
Registrar's No. **5139**

FILED DEC 29 1948
Registration District No. **149**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town 15 Anness City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution 3426 Brooklyn
(If not in hospital or institution, write street number or location)

(d) Length of stay: In-hospital or institution 5 5 3 m (Specify whether in this community years, months or days)

3. (a) PRINT FULL NAME JACOB FINKELSTEIN

3. (b) If veteran, name war V

3. (c) Social Security No. 714-07-1721

4. Sex MO

5. Color or race OW

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Sola Finkelstein

6. (c) Age of husband or wife if alive 77 years

7. Birth date of deceased June 27, 1870
(Month) (Day) (Year)

8. AGE: Years 78 Months 5 Days 20
If less than one day hr. min.

9. Birthplace Omaha Neb.
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business Express Co.

MOTHER FATHER

12. Name Samuel Finkelstein

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

14. Maiden name Sara Schuller

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

16. (a) Informant Sam Stone

(b) Address 37 E. 32nd Ter.

17. (a) Burial (b) Date thereof 12/20/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Elmwood Cem.

18. (a) Signature of funeral director Carroll Hedden

(b) Address 3024 West

19. (a) 12-18-48 (b) Sheraldine Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County Jackson

(c) City or town 15 Anness City
(If outside city or town limits, write "RURAL")

(d) Street No. 3426 Brooklyn
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 17, year 1948 hour 11 minute 35 A.M.

21. I hereby certify that I attended the deceased from March 1948, 1948, to 12-17-48, 1948;
that I last saw him alive on 12-17-48, 1948;
and that death occurred on the date and hour stated above.

Immediate cause of death Generalized Carcinomatous Duration 6 mo

Due to Carcinoma of bladder 1 yr

Due to _____

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: 57-15

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? _____

Geo. C. Kealhofer (Specify type of place) _____
While at work (e) Means of injury _____

23. Signature Geo. C. Kealhofer (M.D. or other) _____
Address 3447 Prospect Date signed 12-17-48

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 Kathryn E. Davidson
Licensed Embalmer No. 3648
P. O. Address A. 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.