

FILED DEC 19 1950

STANDARD CERTIFICATE OF DEATH 5933 State File No. 41734

BIRTH NO. _____ REG. DIST. NO. 274 PRIMARY REG. DIST. NO. 3052 Registrar's No. 386

1. PLACE OF DEATH a. COUNTY Pettis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Pettis	
b. CITY (If outside corporate limits, write RURAL and give township) Longwood		c. CITY (If outside corporate limits, write RURAL and give township) Longwood	
c. LENGTH OF STAY (in this place) lifetime		d. STREET ADDRESS (If rural, give location) Longwood, Missouri	
d. FULL NAME OF HOSPITAL OR INSTITUTION Longwood, Missouri			

3. NAME OF DECEASED (Type or Print) a. (First) MARY	b. (Middle) E.	c. (Last) FINNELL	4. DATE OF DEATH (Month) (Day) (Year) Dec. 9, 1950
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH March 24, 1875	9. AGE (In years last birthday) 75	10. UNDER 1 YEAR Months 8	11. UNDER 1 HR. Days 5	12. UNDER 1 MIN. Hours 5
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home-making	11. BIRTHPLACE (State or foreign country) Pettis County, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME C.N. Lower	13b. MOTHER'S MAIDEN NAME Rebecca Finley	14. NAME OF HUSBAND OR WIFE George H. Finnell
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Huston Finnell	ADDRESS Longwood, Mo.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Aortic Insufficiency Pulmonary Congestion		INTERVAL BETWEEN ONSET AND DEATH 12 hours
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis		
	DUE TO (c)		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		4211

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **May, 1947**, to **Dec 9, 1950**, that I last saw the deceased alive on **Dec 9, 1950**, and that death occurred at **10:30 am.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) John M. Smith	23b. ADDRESS 117 Houstonia	23c. DATE SIGNED 12-10-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12/11/50	24c. NAME OF CEMETERY OR CREMATORY Longwood cemetery	24d. LOCATION (City, town, or county) (State) Longwood, Missouri
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DATE REC'D BY LOCAL REG. 12/11/50	REGISTRAR'S SIGNATURE A. J. Campbell	FUNERAL DIRECTOR'S SIGNATURE M. J. McLean	ADDRESS Madalia, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED 12/18/50

DISTRICT HEALTH OFFICE No. 3

District File Number _____

Date Filed 12-18-50

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed *F. E. Baker*

Licensed Embalmer No. *2419*

P. O. Address *Sedalia 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.