S. No. 300
v. 10.48

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

LED JAN 27 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 110

BIRTH NO. _____ REG. DIST. NO. 13 PRIMARY REG. DIST. NO. 3003 Registrar's No. 6

1. PLACE OF DEATH
a. COUNTY: Barry
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Monett
c. LENGTH OF STAY (in this place): 30 Yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 401 County Monett, Mo.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Barry
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Monett 0051
d. STREET ADDRESS (If rural, give location): 401 County

3. NAME OF DECEASED (Type or Print): a. (First) Flora b. (Middle) Belle c. (Last) Fink

4. DATE OF DEATH (Month) Jan (Day) 15 (Year) 1953

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: July 24, 1880
9. AGE (In years last birthday): 72 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Missouri
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: William Greenway
13b. MOTHER'S MAIDEN NAME: Emiline Donica
14. NAME OF HUSBAND OR WIFE: John Fink (deceased)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME: Mrs. Delores Marshall ADDRESS

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Degeneration — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Hypertension — 15 yrs

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.* 443 x

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-10 *19*45, *to* 1-15-53, *19*____, *that I last saw the deceased alive on* 1-15-53, *19*____, *and that death occurred at* 8:30 P *m., from the causes and on the date stated above.*

23a. SIGNATURE Charles Kerr (Degree or title) MD
23b. ADDRESS Monett Mo
23c. DATE SIGNED 1/19/53

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Jan. 18 1953
24c. NAME OF CEMETERY OR CREMATORY: IOOF
24d. LOCATION (City, town, or county) (State): Monett, Mo.

DATE REC'D BY LOCAL REG. 1-21-1953
REGISTRAR'S SIGNATURE Oliver A. Worrington 465
25. FUNERAL DIRECTOR'S SIGNATURE J. D. Buchanan ADDRESS Monett Mo

(Licensed Embalmer's Statement on Reverse Side)

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 J. W. Buchanan

Licensed Embalmer No. 3179

P. O. Address Monett 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.