

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

31315

State File No.

FILED OCT 6 1954

No. 500
10.48

BIRTH NO. _____		REG. DIST. NO. <u>246</u>		PRIMARY REG. DIST. NO. <u>5P3J</u>		Registrar's No. <u>13</u>			
1. PLACE OF DEATH a. COUNTY <p align="center">NEWTON COUNTY</p>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <p align="center">MISSOURI</p>				b. COUNTY <p align="center">NEWTON</p>	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>RURAL - GALENA TWP</u>)		c. LENGTH OF STAY (In this place) <u>3 YEARS</u>		c. CITY OR TOWN <p align="center">RURAL - GALENA TWP</p>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <p align="center">ROUTE 4, BOX 303</p>				STREET ADDRESS (If rural, give location) <p align="center">ROUTE 4, BOX 303</p>				<u>0730</u>	
3. NAME OF DECEASED (Type or Print) <p align="center">GRANT</p>			a. (First)			b. (Middle)			
c. (Last) <p align="center">FINK</p>			4. DATE OF DEATH (Month) (Day) (Year) <p align="center">SEPT. 26, 1954</p>						
5. SEX <p align="center">M</p>		6. COLOR OR RACE <p align="center">W</p>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, MARRIED (Specify)		8. DATE OF BIRTH <p align="center">MAY 28, 1891</p>		9. AGE (In years last birthday) <u>63</u> IF UNDER 1 YEAR Months Days IF UNDER 1 HR. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <p align="center">SALES EXECUTIVE</p>			10b. KIND OF BUSINESS OR INDUSTRY <p align="center">SERVEL, INC.</p>			11. BIRTHPLACE (City and State or Foreign Country) <p align="center">BLUFFTON, INDIANA</p>		12. CITIZEN OF WHAT COUNTRY? <p align="center">U.S.A.</p>	
13a. FATHER'S NAME <p align="center">JOHN FINK</p>			13b. MOTHER'S MAIDEN NAME <p align="center">NANCY SUTTON</p>			14. NAME OF HUSBAND OR WIFE <p align="center">MRS RUBY FINK</p>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <p align="center">UNK</p>			16. SOCIAL SECURITY NO. <u>311-09-8674</u>			17. INFORMANT'S SIGNATURE OR NAME ADDRESS <p align="center">MRS. K. N. ROE, 708-N. HIGH ST.</p>			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Terminal Pulmonary Edema.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 days.</u>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic Myocarditis</u>						<u>9 months.</u>	
		DUE TO (c) <u>Portal Cirrhosis</u>						<u>2 years.</u>	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <p align="center"><u>5810</u></p>						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>Nov 2, 1952</u> , to <u>Sept 26, 1954</u> , that I last saw the deceased alive on <u>Sept 25, 1954</u> , and that death occurred at <u>8:50 A.M.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>Wm. Wells - Sec. D.O.</u>				(Degree or title)		23b. ADDRESS <u>924 H. Dougherty H.C. Mo.</u>		23c. DATE SIGNED <u>9/26/54</u>	
24a. BURIAL, CREMATION, REMOVAL, BURIAL (Specify)		24b. DATE <u>9-29-54</u>		24c. NAME OF CEMETERY OR CREMATORY <p align="center">OZARK MEMORIAL PARK</p>		24d. LOCATION (City, town, or county) (State) <p align="center">JOPLIN, MISSOURI</p>			
DATE REC'D BY LOCAL REG. <u>9-28-54</u>		REGISTRAR'S SIGNATURE <u>Wm. Wells</u>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <p align="center">STEVE PARKER MORTUARY, JOPLIN, MO.</p>				

(Licensed Embalmer's Statement on Reverse Side)

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

0130

RECEIVED

District Health Officer No. NEWTON COUNTY HEALTH UNIT

District File Number 1054-202

Date Filed OCT 5 1954

NEOSHO, MISSOURI

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.....
Signature of Student Embalmer

Signed Arthur Parker.....

Licensed Embalmer No. 2546

P. O. Address Joplin.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.