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

FILED AUG 30 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28761

BIRTH NO. _____ REG. DIST. NO. 360 PRIMARY REG. DIST. NO. 6225 Registrar's No. 79

1. PLACE OF DEATH
a. COUNTY: Vernon Washington Township
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nevada
c. LENGTH OF STAY (in this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): State Hospital #3

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Vernon
c. CITY OR TOWN: Schell City
d. Is Residence within limits of a city or incorporated town? Yes ☒ No ☐
e. STREET ADDRESS (If rural, give location): 1080

3. NAME OF DECEASED (Type or Print)
a. ~~(First)~~ (LAST): FINKS
b. (Middle): Pearl
c. ~~(Last)~~ (First): Charles, Sr

4. DATE OF DEATH (Month) (Day) (Year): Aug 23, 1955

5. SEX: Male
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Oct 19 1871
9. AGE (In years last birthday): 83 — IF UNDER 1 YEAR: Months 10, Days 0 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): R. R. Agent
10b. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (City and State or Foreign Country): Calhoun Missouri
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: William C. Finks
13b. MOTHER'S MAIDEN NAME: Sarah Burch
14. NAME OF HUSBAND OR WIFE: Lillian Morgan Deceased

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

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): Coronary Vessel Disease — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Arteriosclerotic Heart Disease — 4 yrs
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Fractured Rt Neck of Femur — 9 weeks

19a. DATE OF OPERATION: None
19b. MAJOR FINDINGS OF OPERATION: 4200 F
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT ~~SUICIDE~~ HOMICIDE (Specify): accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Fell at home
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Schell City Vernon Mo

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): June 21 1955 6 P.M.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Result of Fall at Home

22. *I hereby certify that I attended the deceased from* Aug 19, 1955, *to* 23 Aug, 1955, *that I last saw the deceased alive on* 23 Aug, 1955, *and that death occurred at* 1 35 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Frank Dayton, MD
23b. ADDRESS: State Hospital #3
23c. DATE SIGNED: Aug 23 1955

24a. BURIAL, ~~CREMATION, REMOVAL~~ (Specify): Burial
24b. DATE: August 25, 1955
24c. NAME OF CEMETERY OR CREMATORY: Calhoun Cemetery
24d. LOCATION (City, town, or county) (State): Calhoun, Missouri

DATE REC'D BY LOCAL REG.: 8-25-1955
REGISTRAR'S SIGNATURE: Anna E. Ferry 451 O
25. FUNERAL DIRECTOR'S SIGNATURE: Lewis + Son — ADDRESS: Schell City, Mo.

(Licensed Embalmer's Statement on Reverse Side)

SEP 19 1955

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed John G. Lewis

Licensed Embalmer No. 47

P. O. Address Schell

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
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.