

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

1905

State File No.

FILED JAN 14 1957

BIRTH NO. 99159-56 REG. DIST. NO. 184 PRIMARY REG. DIST. NO. 3038 Registrar's No. 3

1. PLACE OF DEATH a. COUNTY <u>Linn</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Linn</u>		
d. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Brookfield</u>		c. LENGTH OF STAY (in this place) <u>4-Days</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Brookfield</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>McLarney Hospital</u>			d. STREET ADDRESS (If rural, give location) <u>McLarney Hospital</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>John</u>		b. (Middle) <u>Grant</u>		c. (Last) <u>Finnell</u>	
4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 4th, 1957</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Baby</u>	8. DATE OF BIRTH <u>Dec. 31st, 1956</u>	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months <u>4</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baby</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Brookfield, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Grant Finnell</u>		13b. MOTHER'S MAIDEN NAME <u>Iva Harriett Knight</u>		14. NAME OF HUSBAND OR WIFE -----	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Grant Finnell Keytesville, Mo.</u>	
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) <u>Pulmonary Hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Erythrobacteriosis ptialis</u> DUE TO (c) <u>Rh incompatibility mother Rh - type O infant Rh + type O.</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>5 days</u>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>7710</u>			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) m.		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>12-31, 1956</u> , to <u>1-4, 1957</u> , that I last saw the deceased alive on <u>1-4, 1957</u> and that death occurred at <u>11: A.</u> , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <u>John R. Dyer M.D.</u>			23b. ADDRESS <u>Brookfield Mo</u>		23c. DATE SIGNED <u>1-5-57</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Jan. 5th, 1956</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Chariton County, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>1-8-57</u>		REGISTRAR'S SIGNATURE <u>Katharine Johnson</u>		25. FOREMAN DIRECTOR'S SIGNATURE ADDRESS <u>Keytesville, Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

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

A. D. Gurnett

Licensed Embalmer No. *3046*

P. O. Address *Key West*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

This body was not embalmed