

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-013283  
STATE FILE NUMBER

FILED MAY 13 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1984

300  
1-57

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>							
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Gen. Hospital</u>			Length of stay in lb <u>7 Yrs</u>		d. STREET ADDRESS (If outside, give location) <u>2801 S.W. Blvd.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>THEODORE</u> Middle <u>FINNEY</u> Last <u>FINNEY</u>				4. DATE OF DEATH Month <u>4</u> Day <u>17</u> Year <u>59</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 20, 1909</u>		9. AGE (In years last birthday) <u>49</u>		10. FUNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self Employed</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>odd jobs</u>		11. BIRTHPLACE (City and state or country) <u>Beaumont, Tex. Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13a. FATHER'S NAME <u>Lewis Finney</u>				13b. MOTHER'S MAIDEN NAME <u>Elsie M. Kinney</u>				14. NAME OF HUSBAND OR WIFE <u>none</u>			
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 Address <u>Mrs Elsie Wright 1300 Penn K.C.Mo</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u>								INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>191X</u>								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)							
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.											
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				20f. CITY, TOWN, OR LOCATION COUNTY STATE			
21. I attended the deceased from <u>4-15-59</u> to <u>4-17-59</u> and last saw <sup>her</sup> him alive on <u>4-17-59</u> Death occurred at <u>11:50 AM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE <u>Abraham Gelpert</u> (Degree or title)				22b. ADDRESS <u>Gen. Hospital</u>				22c. DATE SIGNED <u>4-17-59</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>4-21-59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill Cemetery</u>				23d. LOCATION (City, town, or county) (State) <u>Kansas City Mo</u>			
24. FUNERAL DIRECTOR <u>Sheil Funera) Home</u> ADDRESS <u>K.C.Mo</u>				25. DATE RECD. BY LOCAL REG. <u>4-21-59</u>		26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>					

Abraham Gelpert in Muse ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

vaccines, coroners, etc. must use only standard nomenclature in item 18. No symptoms with 09 listed. All diseases in Part I must be causally related.

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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 *James A. Smith* .....

Licensed Embalmer No. *4954* .....

P. O. Address *K.C. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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