

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 24 1960/157

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-60-006786

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>Jasper</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Jasper</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Carthage</b>		Length of stay in 1b <b>50 yrs</b>		c. CITY OR TOWN <b>Carthage</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>McCune-Brooks hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>737 E. Chestnut St.</b>				
3. NAME OF DECEASED (Type or print) First Middle Last <b>EFFIE D. JONES FINWICK</b>				4. DATE OF DEATH Month Day Year <b>Feb. 13, 1960</b>					
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>12-9-89</b>			
				9. AGE (last birthday) <b>70</b>		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>domestic</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (City and state or country) <b>Trenton, Mo</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>		
13a. FATHER'S NAME <b>William Odom</b>			13b. MOTHER'S MAIDEN NAME <b>Mary Ann Wassom</b>			14. NAME OF HUSBAND OR WIFE <b>Harvey Finwick</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mrs. Eith Myers, Parsons, Kansas</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>4 mo</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Carcinoma of cervix</b>							<b>2 1/2 yrs</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)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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. Month, Day, Year									
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 <b>Sept 20, 1947</b> to <b>Feb 13, 1960</b> and last saw her <sup>her</sup> alive on <b>2-6-60</b> Death occurred at <b>8:10</b> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <i>M. Foster Whitten</i> (Printed name and title) M.D.				22b. ADDRESS <b>616 W. Centennial, Carthage, Mo</b>				22c. DATE SIGNED <b>2-15-60</b>	
23a. BURIAL, CREMATION, REMOVAL, (Specify) <b>burial</b>		23b. DATE <b>2-17-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>East Cemetery</b>		23d. LOCATION (City, town, or county) <b>Lamar, Mo</b>		(State)	
24. FUNERAL DIRECTOR <b>KNELL MORTUARY Carthage, Mo</b>				25. DATE RECD. BY LOCAL REG. <b>2-16-60</b>		26. REGISTRAR'S SIGNATURE <i>E. H. Clinton</i>			

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF \_\_\_\_\_

**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 Robert H. Kneel

Licensed Embalmer No. 4459

P. O. Address Carthage, 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.