

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-007626
STATE FILE NUMBER

Registration District No. 280 Primary Registration District No. _____ Registrar's No. 11

1. PLACE OF DEATH a. COUNTY <u>PLATTE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>LINN</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>GREEN</u>		Length of stay in 1b <u> </u>	c. CITY OR TOWN <u>BROOKFIELD</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>H.WAY 71</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) _____ Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>WAYNE</u> Middle <u>JENNINGS</u> Last <u>FINNEY</u>			4. DATE OF DEATH <u>FEB. 17, 1960</u> Month Day Year			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>3-17-98</u>	9. AGE (last birthday) <u>61</u>	IF UNDER 1 YEAR	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GENERAL</u>	11. BIRTHPLACE (City and state or country) <u>ST. CATHERINE, MO.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>L.S. FINNEY</u>		13b. MOTHER'S MAIDEN NAME <u>SARAH A. BAKER</u>		14. NAME OF HUSBAND OR WIFE _____		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>	(If yes, give war or dates of service) <u>WW I</u>	16. SOCIAL SECURITY NO. <u>531-16-6431</u>	17. INFORMANT <u>CLYDE FINNEY, LINNEUS, MO.</u>	Address _____
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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>CEREBRAL HEMORRHAGE (DIED IN AMBULANCE ENROUTE TO HOSPITAL)</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)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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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 _____ to _____ and last saw her/him alive on _____
Death occurred at APPROX. 1:05p. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Richard M. Giffey, Coroner</u>	22b. ADDRESS <u>Platte City, Mo.</u>	22c. DATE SIGNED <u>2-17-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>2-19-60</u>	23c. NAME OF CEMETERY OR CREMATOR <u>PLEASANT VIEW CEM ST. CATHERINE, MISSOURI</u>
23d. LOCATION (City, town, or county) (State)	24. FUNERAL DIRECTOR <u>Rollins-MITCHELL</u>	25. DATE RECD. BY LOCAL REG. <u>Feb-17-1960</u>
ADDRESS <u>PLATTE CITY, MO.</u>	26. REGISTRAR'S SIGNATURE <u>Ophie Rollins</u>	

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

MAR 24 1960

MAR 1 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed J. R. Knight
Licensed Embalmer No. 4655

P. O. Address Madville

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