MO DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS MAR 23 1960

60-010511 STATE FILE NUMBER

Registration District No. 119 Primary Registration District No. 5442 Registrar's No. 6

1. PLACE OF DEATH
a. COUNTY GASCONADE
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Richland Twp
Length of stay in 1b: 84 YRS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1mi. N. of Pershing
Inside Limits: Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY GASCONADE
c. CITY OR TOWN Richland Twp.
Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) 1mi. N. of Pershing
Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First LANIE Middle BULLARD Last FINLAYSON

4. DATE OF DEATH: Month MARCH Day 12 Year 1960

5. SEX: MALE

6. COLOR OR RACE: CAU.

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 9/6/1893

9. AGE (last birthday): 66
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CONSTRUCTION SUPT.

10b. KIND OF BUSINESS OR INDUSTRY: Building

11. BIRTHPLACE (City and state or country): Rhome Texas

12. CITIZEN OF WHAT COUNTRY: U.S.

13a. FATHER'S NAME: Wm J. FINLAYSON

13b. MOTHER'S MAIDEN NAME: MARGARET DAY

14. NAME OF HUSBAND OR WIFE: GRACE FINLAYSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 454-10-1443

17. INFORMANT: GRACE FINLAYSON. Address RFD MORRISON MO

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Prostate — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 9-27-58 to 3-12-60 and last saw him alive on 3-7-60
Death occurred at 8:45 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Carver T. Shaw, M.D.

22b. ADDRESS: Hermann, Missouri

22c. DATE SIGNED: 3-12-60

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL

23b. DATE: 3/12/60

23c. NAME OF CEMETERY OR CREMATORY: Rhome Texas

23d. LOCATION (City, town, or county) (State): Rhome Texas

24. FUNERAL DIRECTOR ADDRESS: Hugo H Blumer Hermann Mo

25. DATE RECD. BY LOCAL REG.: 3-12-60

26. REGISTRAR'S SIGNATURE: Delma Uffelman

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

MAR 29 1960

STATEMENT BY LICENSED EMBALMER

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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Roger W Bremer

Licensed Embalmer No. 5055

P. O. Address Hermann

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