

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-018844

FILED VS JUN 1 1960 93

Registration District No. \_\_\_\_\_ Primary Registration District No. 4153 Registrar's No. 60-33 STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <b>Dade</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Dade</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Lockwood Mo</b>		Length of stay in 1b <b>2yrs</b>	c. CITY OR TOWN <b>Lockwood Mo</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>Home Chesnut St</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Chesnut St</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>Cora Alice Belle Finley</b>			4. DATE OF DEATH Month Day Year <b>May 15 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>Dec 23 1866 93</b>	9. AGE (last birthday) <b>93</b>	IF UNDER 1 YEAR IF UNDER 24 HR Months <b>4</b> Days <b>22</b> Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>farmer</b>	11. BIRTHPLACE (City and state or country) <b>Tarrafutte Ind</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Emmanuel Rodgers</b>		13b. MOTHER'S MAIDEN NAME <b>Emaline Rodgers</b>		14. NAME OF HUSBAND OR WIFE <b>Teete Finley</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 Eula Fortner Lockwood Mo</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>Dehydration &amp; malnutrition</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Weeks</b> <b>Yrs.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Chronic arteriosclerosis</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 checked="" 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 **3-2-59** to **5-15-60** and last saw <sup>her</sup> alive on **5-13-60**  
Death occurred at **1:15a** m on the date stated above, and to the best of my knowledge, from the causes stated.

21a. SIGNATURE (Degree or title) <b>Emeru Taylor M.D.</b>		21b. ADDRESS <b>Lockwood, Mo</b>		21c. DATE SIGNED <b>5/18/60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>May 17 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lockwood</b>	23d. LOCATION (City, town, or county) (State) <b>Lockwood Mo</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Allison Funeral Home Greenfield Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>5-24-60</b>	26. REGISTRAR'S SIGNATURE <b>J. C. Canada</b>	

(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 \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed W.R. Allison

Licensed Embalmer No. 4404

P. O. Address Greenville

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.