

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-030086

FILED VS AUG 22 1960

STATE FILE NUMBER

Registration District No. 100 Primary Registration District No. _____ Registrar's No. 61

INDEXED

1. PLACE OF DEATH a. COUNTY Lenox Mo. Dent		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Dent	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Lenox Mo.		Length of stay in 1b 50yrs	c. CITY OR TOWN Lenox Mo. Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION His Residence Lenox Mo.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) D- Highway Lenox Mo. Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First OSCAR Middle BAYARD Last FINCH			4. DATE OF DEATH Month August Day 13 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7-26-1879	9. AGE (last birthday) 81	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (City and state or country) North Carolina		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Franklin Finch		13b. MOTHER'S MAIDEN NAME Adeline Goss		14. NAME OF HUSBAND OR WIFE Allie McClure Finch		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) None		16. SOCIAL SECURITY NO. 492-16-7248		17. INFORMANT Address Allie McClure Finch Lenox		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Degenerative Heart disease		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) After seizure	
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

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 7/30/60 to 8-3-60 and last saw him alive on 8/3/60		Death occurred at 6:30A on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE <i>Walter J. Spencer</i> (Degree or title)		22b. ADDRESS <i>Walla Mo</i>	22c. DATE SIGNED 8/13/60
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8-15-60	23c. NAME OF CEMETERY OR CREMATORY Lakespring	23d. LOCATION (City, town, or county) Dent County Mo.
24. FUNERAL DIRECTOR Carl K. Spencer	ADDRESS Salem Mo.	25. DATE RECD. BY LOCAL REG. 8-15-60	26. REGISTRAR'S SIGNATURE <i>M. M. Hart, M.D.</i>

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

David J. Smith

Licensed Embalmer No. *937*

P. O. Address *St. Louis*

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.