

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**-61-032080**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Filed **OCT 5 1967** Primary Registration District No. **3008** Registrar's No. **233**

DATE AMENDED

INSTEAD OF THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>Callaway</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>													
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Fulton, Missouri</b>		Length of stay in 1b <b>40 yrs</b>		c. CITY OR TOWN <b>Kansas City</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>State Hospital No. 1</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>2820 Norton Ave</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) First <b>Beatrice</b> Middle <b>Marjorie</b> Last <b>Finnell</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>28</b> Year <b>1961</b>													
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>3/14/1900</b>		9. AGE (last birthday) <b>61</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>St. Joseph, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>									
13a. FATHER'S NAME <b>Tom Finnell</b>				13b. MOTHER'S MAIDEN NAME <b>Lizzie Phillips</b>				14. NAME OF HUSBAND OR WIFE									
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 <b>State Hospital records</b> Address											
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>Broncho pneumonia with uremia with shock</b> DUE TO (b) <b>Nephrosclerosis with hypertensive cardio vascular disease.</b> DUE TO (c) <b>Insulin resistant diabetes with acetosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Insulin resistant diabetes with acetosis</b>										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 Month, Day, Year a.m. p.m.				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.) <b>State Hospital No. 1</b>		20f. CITY, TOWN, OR LOCATION <b>9/26/21</b> to <b>9/28/61</b>		COUNTY <b>Fulton</b>		STATE <b>Missouri</b>			
21. Attended the deceased from <b>State Hospital No. 1</b> on the date stated above, and to the best of my knowledge, from the causes stated. Death occurred at <b>7:00 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.										22a. SIGNATURE <i>[Signature]</i> (Degree or title) <b>MD</b>		22b. ADDRESS <b>State Hospital No. 1, Fulton, MO.</b>				22c. DATE SIGNED <b>9/28/61</b>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9/30th/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Southside Cemetery</b>				23d. LOCATION (City, town, or county) (State) <b>Fulton, Missouri</b>									
24. FUNERAL DIRECTOR <i>[Signature]</i> ADDRESS <b>Fulton, Mo</b>				25. DATE RECD. BY LOCAL REG. <b>Sept. 29-1961</b>				26. REGISTRAR'S SIGNATURE <i>[Signature]</i>									

(Licensed Embalmer's Statement on Reverse Side)

**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 *Beckett Green*

Licensed Embalmer No. 4220

P. O. Address *Fuller*

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.