

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED DEC 12 1961

-61-042390

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 11364

STATE FILE NUMBER

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Francois</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b>		Length of stay in 1b <b>45 days</b>	c. CITY OR TOWN <b>Farmington</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>St. Louis Childrens</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <b>1102 N. Middle 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>Dewayne James Finch</b>			4. DATE OF DEATH Month Day Year <b>12-5-1961</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</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>6-16-60</b>	9. AGE (last birthday) <b>17mos</b>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (City and state or country) <b>Bonne Terre, Mo.</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>James Rece Finch</b>		13b. MOTHER'S MAIDEN NAME <b>Mary King</b>	
14. NAME OF HUSBAND OR WIFE <b>None</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 <b>Vernell Kunzie</b>		Address <b>500 S. Kingshighway</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>Cardiac arrest; respiratory failure</b> <b>acquired hydrocephalus - post intracranial hemorrhage</b> <b>acquired hydrocephalus - post</b> DUE TO (b) <b>intracranial hemorrhage</b> <b>post meningitis/influenza meningitis</b> DUE TO (c) <b>meningitis</b>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) <b>340.0</b>					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 checked="" type="checkbox"/> NO <input 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 <b>10-21-61</b> , to <b>12-5-61</b> and last saw <sup>her</sup> him alive on <b>12-5-61</b>		Death occurred at <b>2:45 pm</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Malcolm Garber</b>		or title <b>M.D.</b>	22b. ADDRESS <b>St. Louis Children's Hospital</b>		22c. DATE SIGNED <b>12-6-1961</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>12-8-1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Farmington, Missouri</b>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR <b>Cozean F. Home, Farmington, Mo.</b>		ADDRESS		25. DATE RECD. BY LOCAL REG. <b>DEC 6 1961</b>	26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>

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 me,

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Samuel J. Mahan*

Licensed Embalmer No. 4326

P. O. Address Alto M

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.