SEP 24 1930

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

26490

1. PLACE OF DEATH

County Henry — Registration District No. 14 — File No.

Township — Primary Registration District No. 4211 — Registered No. 29

City Windsor (No. , St. Ward)

2. FULL NAME Finis Ewing Means

(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 26 1857

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
73	4	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Windsor
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER Joseph A Means

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Kentucky

12. MAIDEN NAME OF MOTHER Mary B Osborn

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Kentucky

14. INFORMANT A B Means
(Address) Windsor

15. FILED Aug 7 1930 R J Jennings REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 6 1930

17. I HEREBY CERTIFY, That I attended deceased from June 1 1930 to Aug 2 1930 that I last saw him alive on Aug 2 1930, and that death occurred, on the date stated above, at 9 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

1 Paralysis
Influenza

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Influenza

(duration) yrs. mos. 5 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? —

(Signed) [illegible], M. D.

8-7, 1930 (Address) Windsor Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Windsor — DATE OF BURIAL 8-7 1930

20. UNDERTAKER HUSTON'S FUNERAL CHAPEL — ADDRESS Windsor

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT ... FOR CERTIFICATES UNTIL THEY ARE COMPLETED BY LAW

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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Township Primary Registration District No. 4211 Registered No. 29

City Windsor (No. St. Ward)

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(a) Residence. No. St. Ward. (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

SUPPLEMENTARY

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
M	W	M

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.

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(a) Trade, profession, or particular kind of work

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9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. Aug 7, 19 30 T. J. Jennings REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 5 19 30

17. I HEREBY CERTIFY, That I attended deceased from ......, 19...., to ......, 19......

that I last saw h.... alive on ......, 19......, and that death occurred, on the date stated above, at ......m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Paralysis Influenza

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

73A

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DID AN OPERATION PRECEDE DEATH? DATE OF

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(Signed) ......, M. D

, 19 (Address)

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19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS

S-26490