

S. No. 2  
M-5-42  
7-5-17-39  
X32873

8806

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED APR 1 1947

Registration District No. 137

Primary Registration District No. 4218

Registrar's No. 74

1. PLACE OF DEATH:  
 (a) County Henry  
 (b) City or town Calhoun Mo  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution On J. Highway in Calhoun  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution.....  
 (Specify whether  
 In this community.....  
 years, months or days) 63 yr

3. (a) PRINT FULL NAME Jennie Edna Finks  
 3. (b) If veteran, name war C  
 3. (c) Social Security No. ✓

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife William Scott Finks 6. (c) Age of husband or wife if alive 66 years  
 7. Birth date of deceased Dec 15 1883  
 (Month) (Day) (Year)

8. AGE: Years 63 Months 3 Days 8 If less than one day  
 hr. min.

9. Birthplace Princeton Iowa  
 (City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business

MOTHER FATHER { 12. Name W. Scott Graham  
 13. Birthplace Iowa  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Catheran Baird  
 15. Birthplace unknown  
 (City, town, or county) (State or foreign country)

16. (a) Informant Scott Finks  
 (b) Address Calhoun Mo

17. (a) Burial (b) Date thereof 3-26-47  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calhoun Cemetery

18. (a) Signature of funeral director J. Affares  
 (b) Address Calhoun Mo

19. (a) 3-28-47 (b) R. K. Kennedy  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo (b) County Henry 42  
 (c) City or town Calhoun Mo  
 (If outside city or town limits, write "RURAL")  
 (d) Street No.....  
 (If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 23  
 year 1947 hour 8 minute 30 P.M.  
 21. I hereby certify that I attended the deceased from Mar - 17 - 47  
 ..... 19..... to Mar 23 1947  
 that I last saw her alive on Mar 23 1947  
 and that death occurred on the date and hour stated above.

Immediate cause of death.....  
Hypertension  
complete right  
side paralysis.  
thrombosis in  
left brain  
 Due to.....  
 Due to.....  
 Other conditions.....  
 (Include pregnancy within 3 months of death)

Duration

Major findings:  
 Of operations.....  
 Of autopsy.....  
 83A

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify).....  
 (b) Date of occurrence.....  
 (c) Where did injury occur?.....  
 (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
 While at work?.....  
 (Specify type of place) (c) Means of injury.....  
 23. Signature W. J. Wall (M. D. or other) W. J. Wall  
 Address London Date signed 3/24/47

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED  
District Health Officer No. 7,  
District No. 9-47-332  
District File Number  
3-81-47  
Date Filed

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 myself  
....., Registered Apprentice No. ....  
working under my personal supervision.

Signed J. A. Housey  
Licensed Embalmer No. 3502  
P. O. Address Calhoun Mo

**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 this body is not embalmed, fact should be so stated above.