

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

66 0049508

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 139 Primary Registration District No. 3023 Registrar's No. 360

FILED JAN 3 1967

VS 300  
Rev. 4/59

1 0425

2 0420

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4 0

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7 0

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99239

10 46

11 333

12 1-0

13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Henry</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Henry</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clinton</u>		Length of stay in 1b <u>4 days</u>	c. CITY OR TOWN <u>Calhoun</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Clinton General</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Scott Finks</u>			4. DATE OF DEATH Month Day Year <u>Dec 28 1966</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 17 1880 86</u>
9. AGE (last birthday) <u>86</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>	11. BIRTHPLACE (City and state or country) <u>Calhoun, Mo</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. NAME OF HUSBAND OR WIFE <u>Glenn Finks</u>	
13a. FATHER'S NAME <u>William C. Finks</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah E. George</u>	
14. NAME OF HUSBAND OR WIFE <u>Glenn Finks</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Glenn Finks</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar Pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>probable aspiration Vomitus causing</u> DUE TO (c) <u>Chemical type of Pneumonia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>4 days.</u> <u>5 days.</u>	
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 <u>12/24/66</u> to <u>12/28/66</u> and last saw him alive on <u>12/28/66</u> Death occurred at <u>1:30 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Dr. R. S. Halligan M.D.</u>		22b. ADDRESS <u>Clinton Mo</u>	
22c. DATE SIGNED <u>12/29/66</u>		23. LOCATION (City, town, or county) (State) <u>Calhoun Missouri</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12/31/1966</u>	
23c. NAME OF CEMETERY OR CREMATOR <u>Calhoun cemetery</u>		23d. DATE RECD. BY LOCAL REG. <u>Dec 30, 1966</u>	
24. FUNERAL DIRECTOR <u>Sickman-Dunning Funeral Home</u>		26. REGISTRAR'S SIGNATURE <u>Mildred Bigum</u>	

USE BLACK INK OR TYPEWRITER RIBBON

**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 R. L. Dunning

Licensed Embalmer No. 4910

P. O. Address Clinton 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.