

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

Do not use this space.

10732

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township Kan Primary Registration District No. 7
 City Kansas City (No. Kansas City Gen Hosp) St. Gen Hosp Ward

File No. _____
 Registered No. 700

2. FULL NAME

Finley E A
 (a) Residence. No. Keeping Hands Ward. _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widower</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 17 1877

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>57</u>	<u>10</u>	<u>23</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

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

10. NAME OF FATHER James Finley

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

12. MAIDEN NAME OF MOTHER Sarah Nason

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

14. INFORMANT Reverend Clerk
 (Address) Kansas City Gen Hosp

15. FILED 3-13-29 M M Lowe REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-12 1929

17. I HEREBY CERTIFY, That I attended deceased from 3-6 1929 to 3-12 1929
 that I last saw him alive on 3-12 1929 and that death occurred, on the date stated above, at 9:55 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchopneumonia
 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) None
 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____

20. WAS THERE AN AUTOPSY? No

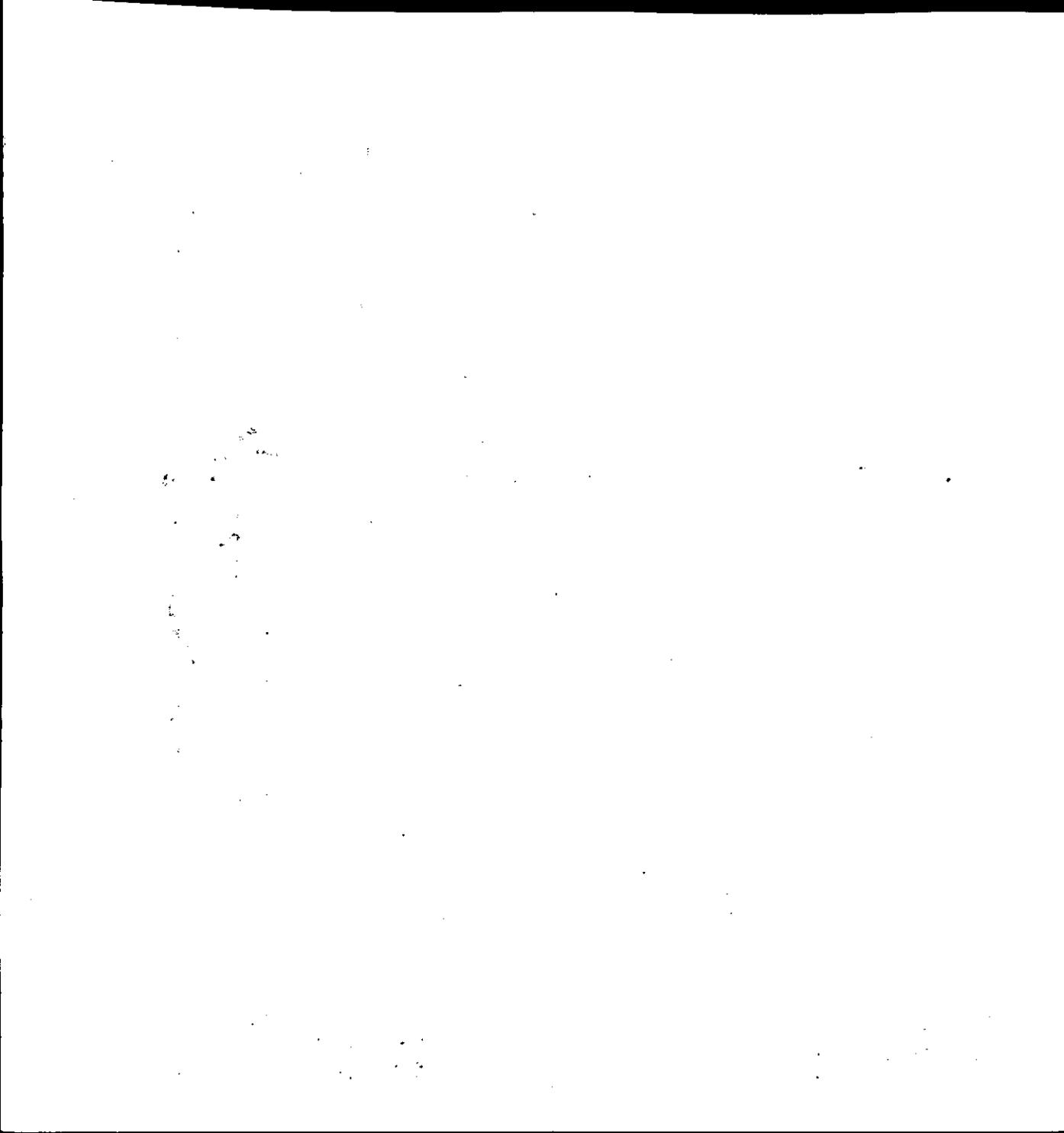
WHAT TEST CONFIRMED DIAGNOSIS Clin Findings
 (Signed) O W Williams, M. D.

3-12-1929 (Address) Sub 72 C Gen Hosp

*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 _____ DATE OF BURIAL 3/10 1929

20. UNDERTAKER W. H. West ADDRESS 1106 East 15



**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No. 399 File No.....
 Township K. City Primary Registration District No. 1002 Registered No. 1240
 City K. City (No.) St. Ward.....

2. FULL NAME

(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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 17-1871

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
57 10 25

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... (duration)..... yrs. mos. ds.
 (b) General nature of industry, business, or establishment in which employed (or employer)..... (duration)..... yrs. mos. ds.
 (c) Name of employer.....

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

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. FILED 3/13, 1929 M. M. G. vance REGISTRAR
W. W. W.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/12 1929

17. I HEREBY CERTIFY That I attended deceased from 19....., 19..... that I last saw h..... alive on 19....., and that death occurred, on the date stated above, at.....

THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)..... (duration)..... yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

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

, 19 (Address)

*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 DATE OF BURIAL

19

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-10732