

MAY 13 1940 547
Registration District No.

Primary Registration District No. **3079**

Registrar's No. **127**

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

1. PLACE OF DEATH:

(a) County Monroe
(b) City or town Hannibal
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St Elizabeth Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 Days
(Specify whether
In this community 4 Day
years, months or days 0 0 5)

3. (a) PRINT FULL NAME JOHN CLEVE FINNIGAN

3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Carolyn 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased SEPT 14 1895
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>54</u>	<u>6</u>	<u>26</u>	hr. min.

9. Birthplace MONROE COUNTY MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation FARMER

11. Industry or business _____

MOTHER FATHER { 12. Name Thomas G FINNIGAN

13. Birthplace Adams Co Illinois
(City, town, or county) (State or foreign country)

14. Maiden name MARY FANE JULLY

15. Birthplace Adams Co Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Harold Van Martin

(b) Address Monroe City, Missouri

17. (a) Removal (b) Date thereof April 11, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Stephens Cemetery

18. (a) Signature of funeral director WILSON & SON

(b) Address Monroe City, Mo

19. (a) 5-12-40 (b) St C. Fisher
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Monroe
(c) City or town Monroe City Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Rural, Indian Creek Township
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 9th
year 1940 hour 3 minute 16 P.M.

21. I hereby certify that I attended the deceased from April 6, 1940, to April 9, 1940
that I last saw him alive on April 9, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Fracture of neck & Paralysis
Duration 3 days

Due to fall

Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) fall

(b) Date of occurrence April 6 - 1940

(c) Where did injury occur? Monroe Co
(City or town) (County) (State)

(d) Did injury occur in or about home, or farm, in industrial place, in public place? 480 Public Place

While at work? no (Specify type of place) (e) Means of injury fall

23. Signature W. A. ... (M. D. or other) _____
Address Hannibal, Mo Date signed 9/12/40

PHYSICIAN
Underline the cause to which death should be charged statistically.

1876
9-17

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 _____

_____, Registered Apprentice No. _____

working under my personal supervision.

Signed Leslie L. Wilson

Licensed Embalmer No. 3014

P. O. Address Memphis City, TN

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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 15-464

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 347

Primary Registration District No. 3029

Registrar's No.

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

1. PLACE OF DEATH:

(a) County... *Marion*
(b) City or town... *Hannibal*
(c) Name of hospital or institution:
(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

3. (a) PRINT FULL NAME... *John Cleve Ferringer*
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex *m* 5. Color or race *w* 6. (a) Single, widowed, married, divorced *wid*

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
54 6 26 hr. min.

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

10. Usual occupation.

11. Industry or business.

12. Name.

13. Birthplace. (City, town, or county) (State or foreign country)

14. Maiden name.

15. Birthplace. (City, town, or county) (State or foreign country)

16. (a) Informant. (b) Address.

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

(c) Place: burial or cremation.

18. (a) Signature of funeral director. (b) Address.

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

20. DATE OF DEATH: Month *apr* day *9* year *1940* hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____; that I last saw him alive on _____ 19 _____; and that death occurred on the date and hour stated above.

Immediate cause of death... *fracture neck paraplegia*

Due to *not known*

Due to _____

Other conditions. (Include pregnancy within 3 months of death) *180 lb 99*

Major findings: Of operations _____

Of autopsy _____

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) (e) Means of injury _____

23. Signature *J. M. Franeka* (M. D. or other) Address *Hannibal Mo* Date signed _____

SUPPLEMENTED BY

PHYSICIAN

Underline the cause to which death should be charged statistically.

