

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

42099
 Do not use this space.

JAN 25 1941

(a) County Carter Registration District No. 142
 (b) Township Jackson Primary Registration District No. 5208 Registered No. 12
 (c) City Winters, Mo. (d) Street No. _____ St. _____
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Robert Eugene Fincher
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Infant
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) February 13, 1940
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
10
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Alton, Mo.

FATHER 13. NAME Clyde Fincher 1
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) West, W. Va. 1

MOTHER 15. MAIDEN NAME Virginia Mark
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Morill, Neb.

17. INFORMANT (ADDRESS) Clyde Fincher
Winters, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. FUNERAL DIRECTOR (NAME) (ADDRESS) G. C. Hood

20. FILED Dec 20 1940 Loyal C. Hood
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) December 13, 1940

22. I HEREBY CERTIFY, That I attended deceased from February 13, 1940, to December 13, 1940
 I last saw him alive on December 13, 1940 Death is said to have occurred on the date stated above, at 8:00 P.M.
 The principal cause of death and related causes of importance were as follows:

Lipomatosis
Generalized hemorrhage from mucous surfaces.
 Date of onset _____
 Other contributory causes of importance: _____

Name of operation _____ Date of _____
 What test confirmed diagnosis? Biopsy Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____ (Signed) J. C. Williams M. D.
 (Address) Alton, Mo.

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.

RECEIVED

District Health Officer No. 5,

District File Number 14154

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

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

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 42099

Registration District No. 145

Primary Registration District No. 2205

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Carter
 (b) City or town Jackson T.P.
 (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 _____ (Specify whether)
 years, months or days

3. (a) PRINT FULL NAME Robert Eugene Triche

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 m

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
		<u>10</u>		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 (b) Date thereof 12 14 1941 (Month) (Day) (Year)

(c) Place: burial or cremation Boyers Chapel

18. (a) Signature of funeral director B. B. Ayres

(b) Address Callisburg, Mo

19. (a) Feb 11-1941 (b) Loyal E. Wood (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Carter
 (c) City or town Grandin Rural (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 Dec day 13 year 1941 hour _____ minute _____ M.

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

Immediate cause of death	Duration
Due to _____	_____
Due to _____	_____
Other conditions _____ (Include pregnancy within 3 months of death)	_____
Major findings: Of operations _____	_____
Of autopsy _____	_____

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) (e) Means of injury _____

23. Signature J. E. Williams (M. D. or other)
 Address Doniphan Date signed _____

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

SUPPLEMENTARY

1940

S-42099