

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **41219**

FILED DEC 24 1946

Registration District No. _____

Primary Registration District No. **5167**

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County **LINCOLN**
 (b) City or town **RURAL TOWNSHIP**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: _____

(If not in hospital or institution, write street number or location) **1**

(d) Length of stay: In hospital or institution _____ (Specify whether

In this community _____
years, months or days)3. (a) PRINT FULL NAME **MARY JANE FINLEY**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **FEMALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **SINGLE**

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

alive _____ years

7. Birth date of deceased **July 22 1874**
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
72 4 10 hr. min.9. Birthplace **LINCOLN Co. Missouri**
(City, town, or county) (State or foreign country)10. Usual occupation **HOUSEWIFE & FARMER**11. Industry or business **OWN FARM**12. Name **ROBERT A. FINLEY**13. Birthplace **LINCOLN Co. Missouri**
(City, town, or county) (State or foreign country)14. Maiden name **MARGARET E. FINLEY**15. Birthplace **LINCOLN Co. Missouri**
(City, town, or county) (State or foreign country)16. (a) Informant **Miss DASSIE FINLEY (Sister)**(b) Address **LINCOLN Co. Mo.**17. (a) **BURIAL** (b) Date thereof **DEC. 5, 1946**
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation **GLADNEY CEM. LIN. Co. Mo.**18. (a) Signature of funeral director **Kemp Funeral Home**(b) Address **1201 Mo.**19. (a) **Dec. 17-1946** (b) **Miss Emma B. Riddle**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State **MISSOURI** (b) County **LINCOLN 57**
 (c) City or town **RURAL TOWNSHIP**
 (If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **DECEMBER** Day **2**
year **1946** hour **7** minute **30 P.M.**

21. I hereby certify that I attended the deceased from

November 10, 1946, to December 7, 1946
that I last saw her alive on **November 37, 1946**
and that death occurred on the date and hour stated above.

Immediate cause of death

**Chronic myocarditis
with cardiac decompensation**

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 **0**23. Signature **J. B. Hogue** (M. D. or other) **M.D.**
Address **W. Whiteville Mo.** Date signed **11/7-46**

MAY 9 1987

RECEIVED
District Health Officer No. 9,
District File Number ~~12-26-1987~~
Date Filed ~~12-26-1987~~

MAY 10 1987

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..... *Joseph J. Marsh*
Licensed Embalmer No. *3982*
P. O. Address..... *Troy, Mississ...*

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.