

No. 2  
1-5-43  
5-17-39  
K38671

DEPARTMENT OF HEALTH  
BUREAU OF THE CENSUS  
FILED JUN 3 1947

THE STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

16749

State File No. \_\_\_\_\_

Registration District No. 387

Primary Registration District No. 5161

Registrar's No. 10

1. PLACE OF DEATH:

(a) County Callaway

(b) City or town NewBloomfield, Mo.  
(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)

(d) Length of stay: In hospital or institution No  
(Specify whether \_\_\_\_\_)

In this community Life  
years, months or days

3. (a) PRINT FULL NAME Adeline E. Finley

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female / 5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Dave Finley

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased 6 30 1863  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>83</u>	<u>10</u>	<u>16</u>	_____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Samuel Fleming

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

14. Maiden name Ann More Virginia

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

16. (a) Informant Frank Finley

(b) Address NewBloomfield, Missouri

17. (a) Burial (b) Date thereof 5/18/1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bull Cemetary

18. (a) Signature of funeral director Ray O'Hall

(b) Address NewBloomfield, Missouri

(c) 5/18/1947 (b) Ray Clapp  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Callaway /

(c) City or town NewBloomfield  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 16  
year 1947 hour 3 minute 50 P.M.

21. I hereby certify that I attended the deceased from Jun 1, 1947 to May 16, 1947  
that I last saw her alive on May 16, 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Valvular Heart Disease

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)

3. Signature E. M. Quirk (M. D. or other) \_\_\_\_\_  
Address New Bloomfield Mo. Date signed 5/18/47

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

RECEIVED  
District Health Officer No. 91  
District File Number  
Date Filed 5-28-47

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..... *Ray A. Holt* .....

Licensed Embalmer No. 2605

P. O. Address. New Bloomfield, Missouri

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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 389Primary Registration District No. 5161Registrar's No. 10

## 1. PLACE OF DEATH:

- (a) County Callaway  
 (b) City or town New Bloomfield  
 (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)

- (d) Length of stay: In hospital or institution \_\_\_\_\_
- 
- (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days)3. (a) PRINT  
FULL NAMEAdeline E. Finley

3. (b) If veteran,
- 
- name war \_\_\_\_\_

3. (c) Social Security
- 
- No. \_\_\_\_\_

## 4. Sex

F5. 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 \_\_\_\_\_

7. Birth date of deceased

June  
(Month)30  
(Day)1946  
(Year)

## 8. AGE:

Years

Months

Days

If less than one day

8316hr. min.

9. Birthplace

(City, town, or county)

(State or foreign country) Mo

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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)
- 
- If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_
- 
- year
- 1947
- hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_
- 
- 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 \_\_\_\_\_

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 sta-  
tistically.

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)  
(c) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

MOTHER FATHER

SUPPLEMENTARY

145 5 1947

MAY 3 1948

16749