

FILED FEB 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1239
295

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City, Mo</u>		c. LENGTH OF STAY (In this place) <u>All</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City, Mo</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1411 Walnut Street</u>				d. STREET ADDRESS (If rural, give location) <u>922 West 79th Street</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>David</u> b. (Middle) <u>Newton</u> c. (Last) <u>FINN</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>1-18-49</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>9-19-1898</u>	9. AGE (In years last birthday) <u>50</u>	IF UNDER 1 YEAR Months Days	IF UNDER 12 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Spray Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Aerion Co</u>		11. BIRTHPLACE (State or foreign country) <u>Jackson Co Missouri</u>		12. CITIZENSHIP OF WHAT COUNTRY? <u>USA No-</u>	
13a. FATHER'S NAME <u>David N Finn</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Ellen Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Mrs Iris Finn</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>496-01-8155</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Iris Finn Wife</u> ADDRESS <u>922 W 79th St</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary occlusion</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>coronary sclerosis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>420.1</u>					INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>4-27, 1948</u> , to <u>11-6, 1948</u> , that I last saw the deceased alive on <u>11-6, 1948</u> , and that death occurred at <u>11:30 Am.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>M. Donald McFarland</u> (Degree or title) <u>M.D.</u>				23b. ADDRESS <u>315 Alameda Rd.</u>		23c. DATE SIGNED <u>1/17/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>1-21-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>1-21-49</u>		REGISTRAR'S SIGNATURE <u>Stroldine Holmes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>France-Wornall Funeral Home K.C. Mo</u> ADDRESS _____			

(Licensed Embalmer's Statement on Reverse Side)

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

Dr. Donald M. McFarland
Plaza, New Albany

St. Joseph's Health Center

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.....

Student Embalmer No.

working under my personal supervision.

Signed Russell N. France

Signed
Student Embalmer

Licensed Embalmer No. 4255

P. O. Address K. C. Mo

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.