

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-004370
STATE FILE NUMBER

Health,
Welfare
Public
Service

FILED MAR 11 1959

Registration District No. 4 Primary Registration District No. _____ Registrar's No. 26

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Atchison</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Atchison</u>	
b. CITY OR TOWN <u>Fairfax</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Fairfax</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Community Hosp</u>		d. STREET ADDRESS (If outside, give location)	
Length of stay in 1b <u>24 yrs.</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Canna</u> Middle <u>Grace</u> Last <u>Finch</u>			4. DATE OF DEATH Month <u>Mar.</u> Day <u>7</u> Year <u>1959</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 6, 1913</u>	9. AGE (In years last birthday) <u>45</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Plattsmouth, Nebr.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Thomas Wiles</u>	13b. MOTHER'S MAIDEN NAME <u>Barbara Jane Linville</u>	14. NAME OF HUSBAND OR WIFE <u>Charles A. Finch</u>
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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>None</u>	17. INFORMANT <u>Miss Helen Finch, Fairfax, Mo</u> Address _____
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>4 years</u> <u>15 years</u>
IMMEDIATE CAUSE (a) <u>Uremia</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pulmonary fibrosis + emphysema</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from <u>February 23, 1959</u> to <u>March 7, 1959</u> and last saw her alive on <u>March 7, 1959</u> Death occurred at <u>10⁰⁰</u> a.m. on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>Edward S. Bue MD</u> (Degree or title)	22b. ADDRESS <u>Tarbio, Mo</u>	22c. DATE SIGNED <u>3/9/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Mar. 9, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Ridge</u>	23d. LOCATION (City, town, or county) (State) <u>Fairfax, Missouri</u>
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24. FUNERAL DIRECTOR <u>SCHOEDER FUNERAL HOME FAIRFAX MO</u>	ADDRESS <u>Therain St. Schooler</u>	25. DATE RECD. BY LOCAL REG. <u>March 9, 1959</u>	26. REGISTRAR'S SIGNATURE _____
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(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

Student
Signature of Student Embalmer

Signed *Marvin N. Schuler*

Licensed Embalmer No. *4162*
P. O. Address *Fairfax, Va.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.