

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-007094  
STATE FILE NUMBER  
2-1124

FILED FEB 17 1959 Registration District No. Primary Registration District No. Registrar's No.

|   |                           |   |   |
|---|---------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Missouri b. COUNTY  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN St. Louis  |                           | c. CITY OR TOWN St. Louis   |   |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |                           | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |   |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 5022 Pennsylvania   |                           | d. STREET ADDRESS (If outside, give location) 5022 Pennsylvania   |   |
| Length of stay in lb  |                           | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br>Lela Mae Finney   |                           |   | 4. DATE OF DEATH<br>Month Day Year<br>January 30, 1959            |
| 5. SEX<br>Female  | 6. COLOR OR RACE<br>White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>January 13, 1906                              |
| 9. AGE (In years last birthday) 53  |                           | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Machine Operator   |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>Wabash Railroad  | 11. BIRTHPLACE (City and state or country)<br>New Bloomfield, Mo. |
| 12. CITIZEN OF WHAT COUNTRY?<br>U.S.  |                           | 13a. FATHER'S NAME<br>Joseph Finney   |   |
| 13b. MOTHER'S MAIDEN NAME<br>Martha Lawson  |                           | 14. NAME OF HUSBAND OR WIFE<br>None   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br>No   |                           | 16. SOCIAL SECURITY NO.<br>488-01-5410  |   |
| 17. INFORMANT<br>Lamine Finney, 5022 Pennsylvania   |                           | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Heart clumping</i><br>DUE TO (b) <i>Tumor of spine</i><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) |                           |   | INTERVAL BETWEEN ONSET AND DEATH<br>yes                           |
| 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.)<br>238K  |   |
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a.m. p.m.   |                           | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20d. INJURY OCCURRED WHILE AT WORK <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  |   |
| 21. I attended the deceased from <i>Jan 1</i> to <i>58</i> and last saw her alive on <i>Jan 30/59</i><br>Death occurred at <i>4:30 p.m.</i> on the date stated above; and to the best of my knowledge, from the causes stated.  |                           |   |   |
| 22a. SIGNATURE<br><i>JTS Dyme</i> (Degree or title)   |                           | 22b. ADDRESS<br><i>2752 Cherokee</i>  |   |
| 22c. DATE SIGNED<br><i>1-31-59</i>  |                           |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Removal  |                           | 23b. DATE<br><i>2-2-59</i>  |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Union Hill Cemetery   |                           | 23d. LOCATION (City, town, or county) (State)<br>New Bloomfield, Mo.  |   |
| 24. FUNERAL DIRECTOR<br>Albert H. Hoppe, 4700 Washington Blvd.  |                           | 25. DATE RECD. BY LOCAL REG.<br>FFB2 '59  |   |
| 26. REGISTRAR'S SIGNATURE<br><i>Carl Smith, M.D.</i>  |                           |   |   |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

**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 *John Shennet* .....  
Licensed Embalmer No. *4194* .....  
P. O. Address *St. Louis* .....

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.