

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-028106

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 33-5 Primary Registration District No. 4030 Registrar's No. 1

FILED AUG 2 1961

|                                                                                                  |  |                                                                                                                                     |                                                                                       |
|--------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Texas</u>                                                      |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo.</u> b. COUNTY <u>Texas</u> |                                                                                       |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Route 4 Summersville</u> |  | c. CITY OR TOWN <u>Summersville</u>                                                                                                 | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>Home</u>       |  | d. STREET ADDRESS (If outside, give location)<br><u>Route 4</u>                                                                     | Reside on Farm<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |

|                                                                                                                 |                            |                                                                                                                                                             |                                                                         |                                           |
|-----------------------------------------------------------------------------------------------------------------|----------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-------------------------------------------|
| 3. NAME OF DECEASED (Type or print)<br>First <u>Alta</u> Middle <u>Lucille</u> Last <u>Finley</u>               |                            |                                                                                                                                                             | 4. DATE OF DEATH<br>Month <u>July</u> Day <u>1</u> Year <u>1961</u>     |                                           |
| 5. SEX <u>F.</u>                                                                                                | 6. COLOR OR RACE <u>W.</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>2/12/20</u>                                         | 9. AGE (last birthday) <u>41</u>          |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u> |                            | 10b. KIND OF BUSINESS OR INDUSTRY                                                                                                                           | 11. BIRTHPLACE (City and state or country)<br><u>Blooming Rose, Mo.</u> | 12. CITIZEN OF WHAT COUNTRY<br><u>USA</u> |

|                                                                                                                       |                                                    |                                                                          |
|-----------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------|
| 13a. FATHER'S NAME<br><u>Walter Kinworthy</u>                                                                         | 13b. MOTHER'S MAIDEN NAME<br><u>Isadore Machon</u> | 14. NAME OF HUSBAND OR WIFE                                              |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u> | 16. SOCIAL SECURITY NO.<br><u>Yes</u>              | 17. INFORMANT<br><u>Roy Boyd</u> Address <u>Route 4 Summersville, Mo</u> |

|                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                      |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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) <u>Transition and debilitation</u><br>DUE TO (b) <u>Carcinomatosis</u><br>DUE TO (c) <u>Primary Adeno Carcinoma of Breast</u><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |  | INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><u>Liver and brain metastases</u>                                                                                                                                                                                      |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |

|                                                                                                                   |                                                                                                           |                                                                                              |
|-------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| 19. WAS AUTOPSY PERFORMED?<br>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.) |
| 20c. TIME OF INJURY<br>Hour _____ a.m. _____ p.m. Month, Day, Year _____                                          |                                                                                                           |                                                                                              |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 Oct 25-60 to June 1961 and last saw her <sup>her</sup> ~~him~~ alive on June 23-61  
Death occurred at \_\_\_\_\_ m on the date stated above, and to the best of my knowledge, from the causes stated.

|                                                                  |                                                |                                                            |
|------------------------------------------------------------------|------------------------------------------------|------------------------------------------------------------|
| 22a. SIGNATURE (Degree or title)<br><u>Dr. Lavere Hampton</u>    | 22b. ADDRESS<br><u>Summersville Mo</u>         | 22c. DATE SIGNED<br><u>7-24-61</u>                         |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>       | 23b. DATE<br><u>7/3/1961</u>                   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>City Cemetery</u> |
| 24. FUNERAL DIRECTOR<br><u>Duncan Funeral Home Mt. View, Mo.</u> | 25. DATE RECD. BY LOCAL REG.<br><u>7-28-61</u> | 26. REGISTRAR'S SIGNATURE<br><u>Julia Powell</u>           |

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED  
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF  
 ITEM NO. SHOULD READ

**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 Charles D. Cartain

Licensed Embalmer No. 5107

P. O. Address Mtn. View

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.