

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-000917

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 93 Primary Registration District No. \_\_\_\_\_ Registrar's No. 63-1

FILED JAN 14 1963

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON  
W.O. Cowan, M.D.

DOCUMENT BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>Dade</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Dade</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Lockwood TWP</b>		c. CITY OR TOWN <b>Lockwood Mo</b>	
Length of stay in 1b <b>yrs</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3 mi S.E. Lockwood</b>		d. STREET ADDRESS (If outside, give location) <b>3 mi S.E. Lockwood Mo</b>	
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Perry</b> Last <b>Finley</b>			4. DATE OF DEATH Month <b>Jan</b> Day <b>1</b> Year <b>1963</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>April 15 1878</b>
9. AGE (last birthday) <b>84</b>		IF UNDER 1 YEAR Months <b>8</b> Days <b>16</b>	
IF UNDER 24 HR Hours <b></b> Min. <b></b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (City and state or country) <b>Dade Co Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>John R Finley</b>		13b. MOTHER'S MAIDEN NAME <b>Martha Daughtrey</b>	
14. NAME OF HUSBAND OR WIFE <b>Bernice Finley</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Samuel Finley Lockwood M rt</b>	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY) IMMEDIATE CAUSE (a) <b>apoplexy</b>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 Hour a.m. _____ p.m. _____ Month, Day, Year _____			
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 <b>Nov - '62</b> to <b>Jan 1, '63</b> and last saw him alive on <b>Dec 18 - '62</b> . Death occurred at <b>1:30p</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>W.O. Cowan M.D.</b> (Degree or title)		22b. ADDRESS <b>Greenfield mo</b>	
		22c. DATE SIGNED <b>1-7-63</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Jan 3 1963</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Lockwood</b>		23d. LOCATION (City, town, or county) (State) <b>Lockwood Mo</b>	
24. FUNERAL DIRECTOR <b>Allison Funeral Home Greenfield Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>1/10/1963</b>	
		26. REGISTRAR'S SIGNATURE <b>J. C. Canada</b>	

**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 W. R. Allison

Licensed Embalmer No. 4404

P. O. Address Greenfield 2000

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.