

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=63-012923

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 3059 Registrar's No. 125 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 3059 Registrar's No. 125 STATE FILE NUMBER

VS 300 Rev. 4/59	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT
1 0941				
2 09412				
3				
4 1				
5 1				
6				
7 0				
8 2				
9 4200				
10				
11 12-0				
13 1-0				
ITEM NO.	SHOULD READ	BY AFFIDAVIT OF		

1. PLACE OF DEATH a. COUNTY <u>St Francois</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>St. Francois</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bonne Terre</u>		c. CITY OR TOWN <u>Bonne Terre</u>	
Length of stay in 1b <u>3 days</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>Bonne Terre Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>407 N. Division</u>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Victoria Alida Finney</u>		4. DATE OF DEATH Month Day Year <u>March 25, 1963</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2-25-1879</u>
9. AGE (last birthday) <u>84</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Valles Mines, Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>US</u>		13a. FATHER'S NAME <u>Richard H. Rowe</u>	
13b. MOTHER'S MAIDEN NAME <u>Alida Sykes</u>		14. NAME OF HUSBAND OR WIFE <u>William H. Finney</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>[REDACTED]</u>	
17. INFORMANT <u>Clinton Finney</u>		Address <u>Bonne Terre, Mo</u> <u>407 N. Division St</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</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) _____			
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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.)	
20c. TIME OF INJURY Hour: _____ a.m. _____ p.m. _____		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 <u>Oct. 1962</u> to <u>Mar. 25, 1963</u> and last saw her <u>live</u> on <u>Mar. 24, 1963</u> Death occurred at <u>1:00</u> <u>a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>[Signature]</u>		22b. ADDRESS <u>Bonne Terre, Missouri</u>	
22c. DATE SIGNED <u>3-27-63</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Mar 28, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove</u>	23d. LOCATION (City, town, or county) (State) <u>St Louis, Mo.</u>
24. FUNERAL DIRECTOR <u>C. Z. Boyer & Son, Inc. Bonne Terre, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Mar 27, 1963</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>

USE BLACK INK OR TYPEWRITER RIBBON

APR 9 1963

APR 9 1963

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 Burton T. Baper, Jr

Licensed Embalmer No. 5117

P. O. Address Bone-Terry 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.