

S. No. 2  
1-8-43  
5-17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

33379

State File No. \_\_\_\_\_

FILED NOV 8 1945

Registrar's No. 348

Registration District No. 53

Primary Registration District No. 3010

1. PLACE OF DEATH:

(a) County Cape Girardeau  
(b) City or town Cape Girardeau  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St Francis Hosp. O  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 days  
In this community 4 days  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Dunklin 35  
(c) City or town Kennett MO  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME William Buchanan Finney

3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

4. Sex Male O 5. Color or race white 6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife Martha Elizabeth Chippard Finney 6. (c) Age of husband or wife if \_\_\_\_\_ years

7. Birth date of deceased Jan 1, 1859  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	86	9	26	hr. _____ min.

9. Birthplace Vienna Ill.  
(City, town, or county) (State or foreign country)

10. Usual occupation Doctor of Medicine

11. Industry or business \_\_\_\_\_

12. Name James Finney

13. Birthplace Richmond Va  
(City, town, or county) (State or foreign country)

14. Maiden name Mary Ann Smith

15. Birthplace Corbendale Ill.  
(City, town, or county) (State or foreign country)

16. (a) Informant Dr MO Finney

(b) Address Chaffee Mo

17. (a) Burial (b) Date thereof Oct 29, 45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cop Ridge Cem Kennett Mo

18. (a) Signature of funeral director Christophers Funeral Home  
(b) Address Chaffee Mo

19. (a) 10-27-1945 (b) Co. G Summers  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 27  
year 1945 hour 7 minute 20 a. M.

21. I hereby certify that I attended the deceased from Oct 23, 1945, to Oct 27, 1945  
that I last saw him alive on Oct 27, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal Hemorrhage

Due to Carcinoma of Intestines

Due to \_\_\_\_\_

Other conditions Anemia  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature H J Ashley (M. D. or other) MD  
Address Cape Girardeau Mo Date signed 12/1/45

Duration

4 days

4 hr

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. Y

District File Number 1145-1273

Date Filed 7-11-6-45

*disorder to*

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Mamie Duplantiff

Licensed Embalmer No. 3242

P. O. Address Chaffee 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 this body is not embalmed, fact should be so stated above.