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JUN 27 1929
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MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

22614

1. PLACE OF DEATH

County St. Louis — Registration District No. 1160 — File No. 59

Township Central — Primary Registration District No. 4470 — Registered No.

City University City (No. ..... St. ..... Ward)

2. FULL NAME Lester M. Finley

(a) Residence. No. 734 Leland Ave. St., ... Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Mary E. Finley

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE: Years 50 — Months 7 — Days 14 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Saleman
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: W. H. Young Bro.

9. BIRTHPLACE (CITY OR TOWN): St. Louis
(STATE OR COUNTRY): Mo

PARENTS

10. NAME OF FATHER: Dr Robt. H. Finley
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY): Mo
12. MAIDEN NAME OF MOTHER: Gillispie
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY): Mo

14. INFORMANT: Mary E. Finley
(Address) 734 Leland Avenue

15. FILED June 20, 1929 Virginia Tuchschmidt Deputy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): June 19, 1929

17. I HEREBY CERTIFY, That I attended deceased from June 19, 19.. to ....., 19.. that I last saw him alive on June 19, 1929, and that death occurred, on the date stated above, at 9:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Alcoholism
Acute exacerbation past 4 days
(duration) 10 yrs. ? mos. ds.

CONTRIBUTORY (SECONDARY): Acute Dilatation of Heart just prior to death (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical Signs

(Signed) A. H. Aid, M. D.
June 20, 1929 (Address) 6194 Delmar Blvd.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Memorial Park — DATE OF BURIAL: June 21, 1929

20. UNDERTAKER: L. B. Shipard — ADDRESS: 1167 Hamilton

...PHYSICIANS should state ... plain terms, so that it may be properly ... statement of OCCUPATION is very important.

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MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County St Louis Registration District No. 1160 File No. 59
Township Primary Registration District No. 4470 Registered No.
City University City (No. St. Ward)

2. FULL NAME Lester M. Finley
(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
M	W	M

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 5, 1878

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
50	7	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED June 20, 1929 Virginia Tuchschmidt Deputy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 19 1929

17. I HEREBY CERTIFY, That I attended deceased from 19 to 19 that I last saw h alive on 19, and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) , M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. [illegible] should be stated [illegible]. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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