

1944
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.
 WHILE FADING—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

State File No. 12386
 Registrar's No. 540

Registration District No. 764

Primary Registration District No. 200

1. PLACE OF DEATH:
 (a) County St. Louis
 (b) City or town Normandy
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
3715 St. Anns Lane
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3
 (Specify whether
 In this community
 years, months or days) 1 = 1/2

3. (a) PRINT FULL NAME James T. Finnell
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Margaret B. Finnell 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May 11, 1865
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
74 10 4 hr. _____ min.

9. Birthplace Macon County Missouri
 (City, town, or county) (State or foreign country)

10. Usual occupation Carpenter

11. Industry or business Retired Dec. 1937

MOTHER FATHER
 12. Name George W. Finnell
 13. Birthplace Kentucky
 (State or foreign country)
 14. Maiden name Elizabeth Perry
 15. Birthplace North Carolina
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature James T. Finnell
 (b) Address 3715 St Anns Lane

17. (a) Burial (b) Date thereof 3/18/40
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Fee Fee Cemetery

18. (a) Signature of funeral director Shepard Funeral Home
 (b) Address 1187 Hamilton Avenue

19. (a) MAR 16 1940 (b) DR. Milton A. Smith
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County St. Louis
 (c) City or town Wellspring
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1661 Vassier Avenue
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month March day 15, 1940
 year 2 hour 15 minute P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw him alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death
General arteriosclerosis
Arteriosclerotic heart disease
 Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 5 months of death)

PHYSICIAN
 Major findings:
 Of operations _____
 Of autopsy _____
 Underline the cause to which death should be charged statistically

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?
707 (Specify type of place)
 While at work? _____ (e) Means of injury _____
 23. Signature Milton A. Smith (M. D. or other) _____
 Address St. Louis County, Mo. Date signed 3/16/40

CM 3353

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.....

Ernest W. Wilkinson

Licensed Embalmer No.....

3575

P. O. Address.....

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, above space should be left blank.