

Filed **JAN -5, 1943**
Registration District No. **318**

Primary Registration District No. **1000**

1. PLACE OF DEATH:
(a) County **Mo.**
(b) City or town **St. Louis**
(c) Name of hospital or institution: **4029 - Fairfax Ave**
(d) Length of stay: **20 years**
In this community **20 years**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **St. Louis**
(c) City or town **St. Louis**
(d) Street No. **4029 - Fairfax Ave**
(e) Citizen of foreign country? **No**

3. (a) PRINT FULL NAME **William Finner**
3. (b) If veteran, name war **None**
3. (c) Social Security No. **488-18-8333**

4. Sex **Male** 5. Color or race **Col.**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Nova Finner**
6. (c) Age of husband or wife if alive **65** years
7. Birth date of deceased **Dec. 24 1875**

8. AGE: Years **66** Months **11** Days **28**
If less than one day hr. min.

9. Birthplace **Vaiden Miss**
(City, town, or county) (State or foreign country)

10. Usual occupation **laborer**

11. Industry or business **Industry**

MOTHER FATHER
12. Name **Charlie Finner**
13. Birthplace **Vaiden Miss**
14. Maiden name **Camilla Heren**
15. Birthplace **Vaiden Miss**

16. (a) Informant **Nova Finner**
(b) Address **4029 Fairfax Ave**

17. (a) **Burial** (b) Date thereof **Dec. 24, 1942**
(c) Place: burial or cremation **Father Dixon Cem.**

18. (a) Signature of funeral director **Manuel Unda Co.**
(b) Address **4029 - Fairfax Ave**

19. (a) **DEC 22 1942** (b) **J. P. Medical**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **24** year **1942** hour **9:30** minute **A** M.
21. I hereby certify that I attended the deceased from **June 6th** to **21st Dec 1942**
that I last saw him alive on **21st Dec 1942**
and that death occurred on the date and hour stated above.

Immediate cause of death **Hepatic carcinoma**
Duration

Due to
Due to
Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations
Of autopsy
PHYSICIAN 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?
(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 **J. P. Medical** (M. D. or other)
Address **2742 Foundry** Date signed

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

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.....

William Finner....., Registered Apprentice No.....

working under my personal supervision.

Signed *William C. McLowell*.....

Licensed Embalmer No. *2114*.....

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, fact should be so stated above.