

ED APR 15 1943

Registration District No. **784**

Primary Registration District No. **720**

1. PLACE OF DEATH:

(a) County **St Louis**
(b) City or town **Koch**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Robert Koch Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 yr 2 mo 16 da**
(Specify whether
In this community **2 yr 2 mo 16 da.**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St Louis**
(c) City or town **St Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **3728 A Lincoln**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **Mae P Finch**

3. (b) If veteran, name war. **-** 3. (c) Social Security No. **none**

4. Sex **F** 5. Color or race **W** 6. (g) Single, widowed, married, divorced. **Married**
6. (b) Name of husband or wife **George H Finch** 6. (c) Age of husband or wife if alive **7** years
7. Birth date of deceased **May 18 1875**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
67 10 2 - hr. - min.

9. Birthplace **Union City Tenn**
(City, town, or county) (State or foreign country)

10. Usual occupation **House wife**

11. Industry or business.....

MOTHER FATHER { 12. Name **J.F. McCutchan**
13. Birthplace **Tenn**
(City, town, or county) (State or foreign country)
14. Maiden name **Martha Patterson**
15. Birthplace **Tenn**
(City, town, or county) (State or foreign country)

16. (a) Informant **Koch Hospital Record**

(b) Address **Koch Mo**

17. (a) **REMOVAL** (b) Date thereof **3 24 43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Corning Ark**

18. (a) Signature of funeral director **Irby Edward Stone**

(b) Address **Corning Ark**

19. (a) **3-24-43** (b) **E. B. McHarran, M.D.**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **20**
year **1943** hour **7** minute **05 P.M.**

21. I hereby certify that I attended the deceased from **1-4-1941** to **3-20-1943**
that I last saw h. **alive** on **3-20-1943**
and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary Tuberculosis**
Duration **30 Mo?**

Due to.....
Due to.....

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **1361**
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? (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) (c) Means of injury.....

23. Signature **Paul Murphy** (M. D. or other)

Address **Koch Mo** Date signed **3-21-43**

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

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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.....

John Ketter

Licensed Embalmer No. *3880*

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.