

S. No. 2
M-5-42
5-17-39
X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12121

FILED MAY 7 1943

Registration District No. 8.2.6 Primary Registration District No. 1003 State File No. _____ Registrar's No. 4031

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2021 Obear Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2021 Obear Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Byrde J. Finnegan
3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced, widowed
6. (b) Name of husband or wife Ralph Finnegan 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 2, 1889
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
53 10 26 hr. _____ min.

9. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)
10. Usual occupation At Home

11. Industry or business _____
12. Name Jacob Gasser
13. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Bertha Schare
15. Birthplace St. Louis, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Bertha Gasser
(b) Address 2120 Obear Ave.

17. (a) Burial (b) Date thereof 5/1/43
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director _____
(b) Address 2117 E. Grand Blvd.

19. (a) APR 30 1943 (b) J. F. Bredick
(Date received local registration) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 28
year 1943 hour 4 minute 45 A.M.
21. I hereby certify that I attended the deceased from Aug. 15
1934 to April 28 1943
that I last saw him alive on April 24 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis
Duration Four years
Due to _____
Due to _____
Other conditions Syphilis For years
(Include pregnancy within 3 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?
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature Peter Heck, M.D. (M. D. or other) _____
Address 4701 St. Louis Ave Date signed 4/28-43

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

MOTHER FATHER

B.M. V. A. Eck
4701 St Louis

Ex 6756 -
11 AM

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 Frank R. Moore
Licensed Embalmer No. 13041
P. O. Address 2117 E. Main

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.