DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 19682

Registration District No. FILED JUL 15 1944 38448 Primary Registration District No. 1003 Registrar's No. 6054

1. PLACE OF DEATH:

(a) County

(b) City or town ST LOUIS MO
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 5134a Easton Ave.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County MO 17 69

(c) City or town ST LOUIS
(If outside city or town limits, write "RURAL")

(d) Street No. 5134A EASTON AVE
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country U

3. (a) PRINT FULL NAME EDWARD FINKLANG

3. (b) If veteran, name war

3. (c) Social Security No. 497-10-6267

4. Sex MALE 0

5. Color or race WHITE

6. (a) Single, widowed, married, divorced WIDOWER 2

6. (b) Name of ~~husband~~ or wife ELIZEBETH

6. (c) Age of husband or wife if alive years

7. Birth date of deceased 12 (Month) 16 (Day) 1882 (Year)

8. AGE: 61 Years 6 Months 19 Days ~~62 7 19~~ If less than one day hr. min.

9. Birthplace Mo (City, town, or county) 0 (State or foreign country)

10. Usual occupation CEMENT FINISHER

11. Industry or business

FATHER
12. Name JOHN FINKLANG
13. Birthplace Mo (City, town, or county) 0 (State or foreign country)

MOTHER
14. Maiden name PAULINE HOUSER
15. Birthplace GERMANY (City, town, or county) 4 (State or foreign country)

16. (a) Informant GEORGE FINKLANG
(b) Address 5134A EASTON AVE

17. (a) CALVARY BURIAL (Burial, ~~cremation, or removal~~) (b) Date thereof 7 (Month) 7 (Day) 44 (Year)

(c) Place: burial ~~or cremation~~ CALVARY

18. (a) Signature of funeral director Joseph F. Quinn
(b) Address 1389 Union Blvd.

19. (a) JUL 7 1944 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JULY day 5th year 1944 hour 2 minute 00 A.M.

21. I hereby certify that I attended the deceased from 6-15-44 ~~7-4-~~, 19 , to 7-4-, 1944 that I last saw him alive on July 4, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Nephritis

Due to

Due to

Other conditions Chronic Alcholism
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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? (Specify type of place)

While at work? (e) Means of injury D

23. Signature C. E. Cochran M.D. (M. D. or other)

Address 1502 N Union Blvd. Date signed 7-5-44

(Licensed Embalmer's Statement on Reverse Side)

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

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 St Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.