

#14266

S. No. 2
M-2-43
5-17-39
I X35697DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSSTATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **11118**Registration District No. **318**Primary Registration District No. **1003**Registrar's No. **2200**

1. PLACE OF DEATH:

(a) County **St. Louis, Missouri**
 (b) City or town **St. Louis, Missouri**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **St. Louis City Hospital-Max C. Stark Memorial**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **6 days**
 In this community **69 years**
 (Specify whether years, months or days)

3. (a) PRINT FULL NAME

MIKE FINN3. (b) If veteran, name war **---**3. (c) Social Security No. **---**4. Sex **male**5. Color or race **white**6. (a) Single, widowed, married, divorced **single**

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive **years**7. Birth date of deceased **October 27th, 1876**

(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

69?**4****8**

hr.

min.

9. Birthplace **Unknown**

(City, town, or county)

(State or foreign country)

10. Usual occupation **Laborer****Unknown**

11. Industry or business

MOTHER FATHER { 12. Name **Henry**13. Birthplace **Unknown**

(City, town, or county)

(State or foreign country)

14. Maiden name **Mary Unknown**15. Birthplace **Unknown**

(City, town, or county)

(State or foreign country)

16. (a) Informant **Mrs. Charles Riley**(b) Address **4440 Laclede Ave.**17. (a) **Burial**

(Burial, cremation, or removal)

(b) Date thereof **3-6-46**

(Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park Cem.**18. (a) Signature of funeral director **Shepard Funeral Home**(b) Address **1167 Hamilton Ave.**

19. (a)

(Date received local registrar)

(b)

(Registrar's signature)

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. **4440 Laclede Ave.**
 (If rural, give location)
 (e) Citizen of foreign country? **no** (Yes or No)
 If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **5th**
 year **1946** hour **4:30** minute **A** M.

21. I hereby certify that I attended the deceased from **2/28/46**
 to **3/5/46**, 19... to... 19...
 that I last saw him **im** alive on **3/5/46**, 19...
 and that death occurred on the date and hour stated above.

Immediate cause of death

Heart failure

Due to

Ischemic aortitis

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy **Ischemic aortitis with Cardiac hypertrophy**

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 **0**23. Signature **K.W. Gregory**

1515 Lafayette

3/5/46 (other)

Address

Date signed

(Licensed Embalmer's Statement on Reverse Side)

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

10050

No Emblam

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.....

Merle Shepard

Licensed Embalmer No.....

3555

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.