

S. No. 2
—12-45
5-17-39
P 1 X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18810

State File No. _____

FILED JUN 13 1947 318

1003

Registrar's No. 5421

Registration District No. _____ Primary Registration District No. _____

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:
City Infirmary 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 yrs., 1 month,
In this community 10 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 5800 Arsenal Street
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME FINLEY, WILLIAM

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 12th, year 1947 hour 3: minute 20 A.M.

21. I hereby certify that I attended the deceased from July 2, 1945, to May 12th, 1947;

that I last saw h. im alive on May 12th, 1947;

and that death occurred on the date and hour stated above.

4. Sex Male 2 5. Color or race Colored

6. (a) Single, widowed, married, divorced Single 0

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

7. Birth date of deceased June 2nd, 1888
(Month) (Day) (Year)

Immediate cause of death generalized arterio-sclerosis - several years

Duration _____

8. AGE: Years Months Days If less than one day

58 11 10 hr. _____ min.

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: _____

Of operations _____

Of autopsy _____

9. Birthplace Springfield, Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Nil

11. Industry or business _____

MOTHER FATHER { 12. Name Robert Finley 9

13. Birthplace Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Weaver

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant City Infirmary records, 1

(b) Address 5800 Arsenal Street

17. (a) Anatomical Board Date thereof 5-19-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director W. Richter

(b) Address 3590 Rutger St

19. (a) JUN 2 1947 (b) J. F. Brudick
(Date received local registrar) (Registrar's signature)

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 Edmund Quinn Bowditch (M. D. or other) _____
Address _____ Date signed _____

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.....

Licensed Embalmer No.....

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.