

FILED AUG 12 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

24272

Registration District No. 318

Primary Registration District No. 1003

Registrar's No.

6906

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: Firmine Desloge Hosp. O
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 hours
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME

Joseph Finnegan

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced 0
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 8-5-48
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 7 hr. _____ min.

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

10. Usual occupation None

11. Industry or business _____

12. Name Thomas James Finnegan
13. Birthplace St. Louis, Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Virginia Elizabeth Michelson
15. Birthplace St. Louis, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Thomas Finnegan
(b) Address 2620 Lemp Ave.
Burial (c) Date thereof 8/6/48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Resurrection Cemetery

18. (a) Signature of funeral director John H. Gebken Sons and Co.
2630 Gravois Ave.
(b) Address _____
19. (a) AUG 6 - 1948 (b) J. F. Budeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County foo
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2620 Lemp 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 8 day 5
year 48 hour 10 30 minute A. M.
21. I hereby certify that I attended the deceased from 8/5/48
to 8/5/48, 1948
that I last saw him 9:00 alive on 8/5/48
and that death occurred on the date and hour stated above.

Immediate cause of death Wheeler, bilateral Prematurity

Due to _____

Due to 157

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

Major findings: Of operations _____

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? _____
(Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature Resurrection M.D. (M. D. or other)
Address 1325 So. Grand Date signed 8/5/48

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.....

Robert J. Gibbens

Licensed Embalmer No. 4144

P. O. Address 2630 Gravois Ave.

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.