

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7535**
1777
Registrar's No.

No. 300
10-48

FILED MAR 11 1953

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE		b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis		c. LENGTH OF STAY (In this place) 10hrs		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Baptist Hosp.		d. STREET ADDRESS (If rural, give location) 307 St. Louis Ave.			
3. NAME OF DECEASED (Type or Print) a. (First) Louis		b. (Middle) Henry		c. (Last) Fink	
4. DATE OF DEATH (Month) (Day) (Year) 2--14--1953		5. SEX Male		6. COLOR OR RACE white	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH 10--5--1869		9. AGE (In years last birthday) 83	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. M.R.R Engineer		10b. KIND OF BUSINESS OR INDUSTRY Wabash R.R.		11. BIRTHPLACE (State or foreign country) Florissant, Mo	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Peter Fink		13b. MOTHER'S MAIDEN NAME Regina Weiss	
14. NAME OF HUSBAND OR WIFE Anna Schlueter Fink		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT'S SIGNATURE OR NAME Mrs. Louis H. Fink		17. ADDRESS Ferguson, Mo		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) Cerebral Hemorrhage	
19. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION none		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 331X	
22. I hereby certify that I attended the deceased from June, 1947 , to Feb, 1953 , that I last saw the deceased alive on 2-13-1953 , and that death occurred at 3:00 A.M. , from the causes and on the date stated above.					
23a. SIGNATURE M.D. Ferguson		(Degree or title)		23b. ADDRESS Ferguson Mo	
23c. DATE SIGNED 2/16/53		24a. BURIAL, CREMATION, REMOVAL (Specify) removal		24b. DATE 2-17-1953	
24c. NAME OF CEMETERY OR CREMATORY Laurel Hill Gardens		24d. LOCATION (City, town, or county) (State) St. Louis, Mo			
DATE REC'D BY LOCAL REG. FEB 16 1953		REGISTRAR'S SIGNATURE Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE White Chapel, Ferguson, Mo	
25. ADDRESS		25. ADDRESS			

WRITE PLAINLY—USING 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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Eleanora Bonnie

Licensed Embalmer No. 3403

P. O. Address Jennings N

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.