

FILED NOV 22 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH38723  
State File No. 8413

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>8413</b>	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). b. STATE <b>Missouri</b> c. CITY OR TOWN <b>Ferguson 4109,</b> d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>				c. LENGTH OF STAY (In this place) <b>36 hrs</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>De Paul Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>915 Highmont</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>LAURA</b> b. (Middle) <b>FINK</b> c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) <b>Sept. 9, 1954</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>8-1-1886</b>	9. AGE (In years last birthday) <b>68</b>	IF UNDER 1 YEAR Months Days	IF UNDER 100 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Unknown</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Leroy F. Fink</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Leroy F. Fink, Ferguson, Mo.</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Chronic Myocarditis</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Rheumatic Heart disease with decompensation</b> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			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) (M.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>416 X</b>			
22. I hereby certify that I attended the deceased from <b>April 1, 1953</b> , to <b>Sept 11, 1954</b> , that I last saw the deceased alive on <b>Sept 10, 1954</b> , and that death occurred at <b>8:12 A. m.</b> , from the causes and on the date stated above.							
22a. SIGNATURE (Degree or title) <b>Walter Moore M.D.</b>			22b. ADDRESS <b>7315 Pasadena Blvd</b>		22c. DATE SIGNED <b>9/13/54</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>9-14-54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hill Gardens</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Mo.</b>		
DATE REC'D BY LOCAL REG. <b>SEP 14 1954</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>WHITE CHAPEL, FERGUSON, MISSOURI</b>			

(Licensed Embalmer's Statement on Reverse Side)

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.....  
Signature of Student Embalmer

Signed *Eleana Province*.....

Licensed Embalmer No. *340*.....

P. O. Address *Jennings*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.