Health, & Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-014961
STATE FILE NUMBER

FILED APR 20 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 3340

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY
b. CITY OR TOWN ST. LOUIS Mo — Inside Limits Yes ☐ No ☐	c. CITY OR TOWN ST. LOUIS — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 3400 JUNIATA — Length of stay in Ib	d. STREET ADDRESS (If outside, give location) 3400 JUNIATA — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First ELLEN, Middle CECILIA, Last FINN

4. DATE OF DEATH: Month APRIL, Day 2, Year 1959

5. SEX: Female

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAY 19 1888

9. AGE (In years last birthday): 70 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED LAUNDRY WORKER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): ENGLAND

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: THOMAS FINN

13b. MOTHER'S MAIDEN NAME: BRIDGET DUFFY

14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: ELEANOR FINN Address 3400 JUNIATA

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinoma of lung.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Generalized metastasis

DUE TO (c) 163X

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) —

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year —

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —

20f. CITY, TOWN, OR LOCATION — COUNTY — STATE —

21. I attended the deceased from Jan. 2, 1957 to April 2, 1959 and last saw her/him alive on April 2, 1959. Death occurred at 10:20 p.m. on the date stated above, and to the best of my knowledge from the causes stated.

22a. SIGNATURE: A. F. Plag (Degree or title) M.D.

22b. ADDRESS: 3150 Morganford Rd

22c. DATE SIGNED: 4/3/59

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL

23b. DATE: Apr. 6 1959

23c. NAME OF CEMETERY OR CREMATORY: MT. OLIVE CEMETERY

23d. LOCATION (City, town, or county) (State): ST. LOUIS Mo

24. FUNERAL DIRECTOR: Thomas Kuhs ADDRESS: 2906 Gravois

25. DATE RECD. BY LOCAL REG.: APR 3 '59

26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

mJB

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 Eleanor Downie

Licensed Embalmer No. 3403

P. O. Address Jamaica, N.Y.

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.