

**U.S. DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-038477**

FILED VS. **188600-17**  
 REGISTRATION DISTRICT NO. **1959**

R# **120259**

Primary Registration District No. **500**

Registrar's No. **2637**

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>JEFFERSON BARRACKS, MO.</b>		Length of stay in 1b <b>659 DAYS</b>		c. CITY OR TOWN <b>ST. LOUIS</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VETERANS ADMIN. HOSPITAL</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2532a ST. LOUIS AVENUE</b>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>LIBERTY</b> Middle <b>ODIS</b> Last <b>FINLEY</b>				4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>3</b> Year <b>1959</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>12-18-92</b>	9. AGE (last birthday) <b>66</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER - RETIRED</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>UNKNOWN</b>	11. BIRTHPLACE (City and state or country) <b>FAIRFIELD, ILLINOIS</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>RICHARD FINLEY</b>			13b. MOTHER'S MAIDEN NAME <b>REBECCA BUIS</b>		14. NAME OF HUSBAND OR WIFE <b>ROSIE LEE FINLEY</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WW-1</b>			16. SOCIAL SECURITY NO. <b>431422599</b>	17. INFORMANT Address <b>VA HOSPITAL RECORDS, JEFF BRKS, MO.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RECENT MYOCARDIAL INFARCTION</b>							INTERVAL BETWEEN ONSET AND DEATH <b>24-36 HRS</b>
DUE TO (b) <b>CORONARY ARTERIOSCLEROSIS</b>							
DUE TO (c) <b>4201</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>ARTERIOSCLEROSIS, GENERALIZED</b>							PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. <b>VA</b> attended the deceased from <b>12-13-57</b> to <b>10-3-59</b> Death occurred at <b>7:45 AM</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>W. Oppler, M.D., DIRECTOR PROFESSIONAL SERVICES, VET ADM HOSP, JEFF BRKS, MO.</b>				22b. ADDRESS <b>10-3-59</b>		22c. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>OCT. 6, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT. LEBANON</b>		23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS COUNTY, MO.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>SUEDMEYER &amp; SONS 3934 N. 20TH ST.</b>			25. DATE RECD. BY LOCAL REG. <b>10-5-59</b>		26. REGISTRAR'S SIGNATURE <b>J. B. Murphy, M.D.</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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

*Laurence O. Berling*

Licensed Embalmer No. 4972

P. O. Address St. Louis

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.