URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

-60-008195
STATE FILE NUMBER

FILED VS MAR 7 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 2053

NDED

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Length of stay in 1b 60 yrs.	c. CITY OR TOWN St. Louis — Inside Limits Yes ☑ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 3612 N. Spring Ave. — Inside Limits Yes ☑ No ☐	d. STREET ADDRESS (If outside, give location) 3612 N. Spring Ave. — Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print)	First: Mary	Middle: E.	Last: Finn	4. DATE OF DEATH	Month: February Day: 20, Year: 1960
5. SEX: Female	6. COLOR OR RACE: White	7. Married ☐ Never Married ☐ Widowed ☑ Divorced ☐	8. DATE OF BIRTH: 8-15-1877	9. AGE (last birthday): 82	IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HR: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY: ----	11. BIRTHPLACE (City and state or country): Ireland	12. CITIZEN OF WHAT COUNTRY: U.S.A.		
13a. FATHER'S NAME: Patrick Carroll	13b. MOTHER'S MAIDEN NAME: Bridget Quinn	14. NAME OF HUSBAND OR WIFE: John Finn (Deceased)			
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.: None	17. INFORMANT: Mr. Thomas J. Finn	Address: 4546 N. Kingshighway		

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

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 hr

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

DUE TO (b) Arteriosclerosis General — 10 years

DUE TO (c) 332x

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

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☑ No ☐ Unknown

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 2/6/57, to 2/20/60 and last saw her/him alive on 2/20/60

Death occurred at 12:57 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Louis F. Stephens M.D.	22b. ADDRESS: 3207 So Grand Ave	22c. DATE SIGNED: 2/22/60	
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 2-23-1960	23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery	23d. LOCATION (City, town, or county) (State): St. Louis, Missouri
24. FUNERAL DIRECTOR: Arthur J. Donnelly	ADDRESS: 3840 Lindell Blvd.	25. DATE RECD. BY LOCAL REG.: FEB 22 1960	26. REGISTRAR'S SIGNATURE: Carl Smith, M.D. MJB

(Licensed Embalmer's Statement on Reverse Side)

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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Francis Willia

Signature of Student Embalmer

Licensed Embalmer No. 356

P. O. Address 3840 Lu

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co 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.