

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

36219  
Do not use this space.

NOV 15 1937

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Registered No. 9796

1. PLACE OF DEATH

(a) County ..... Registration District No. ....  
(b) Township ..... Primary Registration District No. 2 .....  
(c) City St. Louis ..... (d) Street No. 3447 Halliday Ave. ..... St. ....  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Marie Finster

(a) Residence, No. 3447 Halliday Ave. ..... St. 76 .....  
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 26th, 1863.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
73 9 25

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. At Home  
9. Industry or business in which work was done, as saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Hungary

13. NAME Joseph Finster

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Hungary

15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Hungary

17. INFORMANT Mrs. Henry Zimmermann  
(ADDRESS) 3447 Halliday Ave.

18. BURIAL, CREMATION, OR REMOVAL PLACE Mo. Crematory DATE Oct. 23rd, 1937

19. FUNERAL DIRECTOR Wacker-Helderle  
(ADDRESS) 2331 S. Broadway

20. FILED OCT 22 1937 J. Bredbeck  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 21st, 1937

22. I HEREBY CERTIFY, That I attended deceased from Oct. 10, 1937, to Oct. 21, 1937

I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at 4.30 A.M.

The principal cause of death and related causes of importance were as follows:

Cerebral Hemorrhage Date of onset 11 day

Other contributory causes of importance: Hypertension

Name of operation..... Date of.....  
What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....  
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) L. P. H. H. H. M. D.  
(Address) 5817 Grand

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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STATEMENT BY LICENSED EMBALMER

I, Robert Wheeler, Licensed Embalmer No. 2128

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

L. E.

No. 2128 or by \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed Robert Wheeler

Licensed Embalmer No. 2128

**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.)**