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.

DEC'D MAY 10 1939

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

791
1003

12796
Do not use this space.

3138

1. PLACE OF DEATH

(a) County ..... Registration District No. .....

(b) Township ..... Primary Registration District No. ..... Registered No. .....

(c) or City St. Louis (d) Street No. Lutheran Hospital St.
(If death occurred in Hospital or Institution, write its name instead of street and number)

(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.

552

2. PRINT FULL NAME FREDERICK C. FINNINGER

(a) Residence, No. 5446 West Florissant Avenue St. 8
(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Male	White	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Louise D. Finninger (Brunkhorst)

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 19, 1899

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	39	3	13	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Baker
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) St. Louis Mo

FATHER
13. NAME Louis Finninger
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany 0

MOTHER
15. MAIDEN NAME Adele Kern 6
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany 6

17. INFORMANT (ADDRESS) Mrs. Louis D. Finninger
5446 West Florissant Avenue

18. BURIAL, CREMATION, OR REMOVAL
PLACE Bellefontaine DATE Apr. 4, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Math. Hermann & Son
2161 East Fair Avenue

20. FILED APR 3 1939, 19.... J. F. Bredeck Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr. 1, 1939

22. I HEREBY CERTIFY, That I attended deceased from Feb. 20th, 1939, to April 1st, 1939
I last saw him alive on April 1st, 1939. Death is said to have occurred on the date stated above, at 6:45 A. M.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Glomeruli nephritis	18 months

Other contributory causes of importance:

Name of operation None Date of .....
What test confirmed diagnosis? Lab. Was there an autopsy? None

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? No
If so, specify .....
(Signed) Herbert G. Lund, M. D.
(Address) 3651 Grandel dg

(Licensed Embalmer's Statement on Reverse Side)

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Leonard Hampton

Licensed Embalmer No. 2967

P. O. Address 2161 E. Fair

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.