

Registration District No. 784

Primary Registration District No. 2nd

Registrar's No. 1610

1. PLACE OF DEATH:

(a) County St. Louis County
(b) City or town Jefferson Barracks
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Veterans Administration Facility
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Admitted 8/5/40
(Specify whether years, months or days) unknown

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limit: write "RURAL")
(d) Street No. 4819 Fountain Avenue
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 22nd
year 1940 hour 4:55 minute p. M.

21. I hereby certify that I attended the deceased from August 5, 1940 to August 22, 1940;
that I last saw him alive on August 22, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death: Nephritis, chronic, with nitrogen retention. Duration 5 yrs.

Due to _____

Due to _____

Other conditions: Hypertrophy of prostate with urinary obstruction. 2 yrs.

Major findings: Of operations Aug. 16, 1940, Prostatectomy.

Of autopsy No autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) NO

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State) _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) _____ (e) Means of injury _____

23. Signature C. W. HUGHES, M.D. (M. D. or other) !
Address Chief Medical Officer, Date signed 8/22/40

3. (a) PRINT FULL NAME Herman A. Finke 520

3. (b) If veteran, name war Spanish-Amer. 3. (c) Social Security No. None

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Bertha 6. (c) Age of husband or wife if alive - years

7. Birth date of deceased January 23 1879
(Month) (Day) (Year)

8. AGE: Years 61 Months 6 Days 29 If less than one day _____ hr. _____ min.

9. Birthplace Collinsville Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Architect

11. Industry or business -

12. Name Unavailable

13. Birthplace Unavailable
(City, town, or county) (State or foreign country)

14. Maiden name Unavailable

15. Birthplace Unavailable
(City, town, or county) (State or foreign country)

16. (a) Informant M. Schullig

(b) Address Clinical Clerk, VAF, Jeff. Bks., Mo.

17. (a) Burial (b) Date thereof 8-26-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation National Cemetery

18. (a) Signature of funeral director C. Hoffmeister, Inc. Co.

(b) Address 7814 S. Broadway Ave.

19. (a) AUG 24 1940 (b) [Signature]
(Date received local registrar) (Registrar's signature)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

6

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 Linda C. Hoffmeister
Licensed Embalmer No. 3871
P. O. Address 7814 S. Broadway

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