

No. 2
-5-43
-17-39
X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33072
State File No. _____
Registrar's No. **9453**

FILED NOV 10 1943
Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
DePaul Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 Days**
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME **Timothy J. Finn**
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Oct. 24 1943**
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days **2** If less than one day _____ hr. _____ min.

9. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **None**

11. Industry or business _____

MOTHER { 12. Name **John J. Finn**
13. Birthplace **New York**
(City, town, or county) (State or foreign country)
14. Maiden name **Agnes Rose Timlin**
15. Birthplace **St. Louis, Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Agnes R. Finn**
(b) Address **3925 Vest Ave.**
17. (a) **Burial** (b) Date thereof **10/27/43**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Calvary**

18. (a) Signature of funeral director _____
(b) Address **2117 E. Grand Blvd.**
19. (a) **Oct 27 1943** (b) **J. F. Budeck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **3925 Vest Ave.**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **26**
year **1943** hour **11** minute **30A** M.

21. I hereby certify that I attended the deceased from **Oct. 24** 19**43** to **Oct. 26** 19**43**
that I last saw him alive on **Oct. 26** 19**43**
and that death occurred on the date and hour stated above.

Immediate cause of death:
Prematurity
6 months gestation
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

Major findings:
Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(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 **Henry C. Westerman** (M. D. or other) **M.D.**
Address **2136 E. Grand Blvd.** Date signed **10-27-43**

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.

Not Embalmed
Signed *Frank A. [unclear]*

Licensed Embalmer No. *3041*

P. O. Address *2117 E. [unclear]*

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, fact should be so stated above.