

Dy. Gerla Small 103

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 13 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5100
Registrar's No. 2119

Registration District No. 318

Primary Registration District No. 1003

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: De Paul Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 Hrs.
In this community _____
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL") 910
(d) Street No. 3606 N. Spring Ave.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Leo Patrick Finnegan

3. (b) If veteran, name war _____ 3. (c) Social Security No. 488-09-1155

4. Sex M 5. Color or race W 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 March 17 1892
(Month) (Day) (Year)

8. AGE: Years 51 Months 11 Days 14 If less than one day hr. _____ min. _____

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

10. Usual occupation Laborer

11. Industry or business _____

12. Name Thomas Finnegan

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

14. Maiden name Catherine Clifford

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

16. (a) Informant Madonna Finnegan
(b) Address 3606 N. Spring Ave.

17. (a) Burial (b) Date thereof 3/4/44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Stroot-Carroll
(b) Address 4600 Natural Bridge Blvd.

19. (a) MAR 3 1944 (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 1 year 1944 hour 1 minute 40 A. M.

21. I hereby certify that I attended the deceased from 6-3-43 to 9-7-44 that I last saw him alive on 3-1-44 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 2 hrs

Due to arteriosclerosis

Due to hypertensive cardio vascular disease

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

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

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 plant) (c) Means of injury _____

23. Signature Wayne O. Spohn (M. D. or other) _____
Address 3722 N. 3rd Date signed 3-2-44

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

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 *Sheldon Collier*

Licensed Embalmer No. *3382*

P. O. Address.....

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.