

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. **10286**

**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:  
4224a McRee Ave.  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution.....  
(Specify whether  
 In this community.....  
years, months or days)

**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. 4224a McRee Ave.  
(If rural, give location)  
 (e) Citizen of foreign country?..... (Yes or No)  
 If yes, name country..... 0

**3. (a) PRINT FULL NAME** William C.C. Finley

3. (b) If veteran, name war Nil

3. (c) Social Security No. Unknown

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Dec. day 4  
 year 1944 hour 6:00 minute 6:22 P. M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....;

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mollie E. Finley

6. (c) Age of husband or wife if alive 72 years

7. Birth date of deceased September 29 1875  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
69 2 5 hr. min.

that I last saw h..... alive on....., 19....., and that death occurred on the date and hour stated above.

Immediate cause of death Cubing Luis Pedem  
abnorr Cardiac Hypertrophy  
while being heated for a broiler  
and fractured 6 ribs left side  
received when he was thrown  
down and pawed by a bull  
on his farm one mile  
east of Keosauqua, Ill.

Other conditions east of Keosauqua, Ill.  
(Include pregnancy within 3 months of death)

Major findings Oct 12 1944 heart  
 Of operation heart  
 Of autopsy heart

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

10. Usual occupation Factory Worker

11. Industry or business General Cable Co.

MOTHER FATHER { 12. Name William Finley

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

14. Maiden name Laura Ward

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

16. (a) Informant Mrs. Mollie Finley

(b) Address 4224a McRee Ave.

17. (a) Removal (b) Date thereof 12-5-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenville, Ill.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) DEC 5 1944 (b) J. J. Credet  
(Date received local registrar) (Registrar's signature)

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

(a) Accident, suicide, or homicide (specify) Accident 12/4

(b) Date of occurrence Oct 12 1944

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

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

While at work? yes (b) Means of injury saawer

23. Signature Alfred Perry (M. D. or other)  
 Address Keosauqua Date signed 12/5/44

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

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

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**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..... *Albert G. Hopper* .....

Licensed Embalmer No..... *2971* .....

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.**