

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 6222

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:  
Missouri Baptist  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. 5 days  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days) 0

3. (a) PRINT FULL NAME John M Finn  
3. (b) If veteran, name war. No 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 Cornelia Finn 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Jan. 13 1869  
(Month) (Day) (Year)

8. AGE: Years 76 Months 6 Days 4 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Saint Louis, Missouri  
(City, town, or county) (State or foreign country)  
10. Usual occupation Retired Molder

11. Industry or business \_\_\_\_\_  
12. Name John Finn  
13. Birthplace St. Louis, Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name UNKNOWN  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Neal Ilges  
(b) Address 2036 East Prairie  
17. (a) Burial (b) Date thereof. 7/21/45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation. Calvary Cemetery

18. (a) Signature of funeral director. H. A. Stock  
(b) Address 2117 East Grand  
19. (a) JUL 18 1945 (b) J. J. [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County 000  
(c) City or town Saint Louis  
(If outside city or town limits, write "RURAL") 17 9  
(d) Street No. 2036 East Prairie  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month July day 17  
year 1945 hour 11 minute 40 P.M.  
21. I hereby certify that I attended the deceased from about 17, 1945, to July 17, 1945  
that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death 2 tubercles cerebral  
Due to \_\_\_\_\_  
Due to arteriosclerosis  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

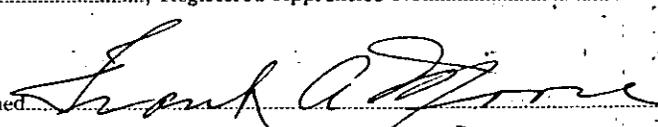
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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?  
(Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
23. Signature [Signature] (M. D. or other) 0 M. D.  
Address 1218 E. [Address] Date signed \_\_\_\_\_

**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.....



Licensed Embalmer No. 3041

P. O. Address 2117 E. Grand

**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.**