

FILED SEP 14 1945

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 7870

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:
City Infirmery
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 Days
(Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis
(If outside city or town limits, write "RURAL") 1773
(d) Street No. 2327 So. 12th St.
(If rural, give location) 9
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Jerry Finley

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 July 24 1945
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 13 hr. min.

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

10. Usual occupation Nil

11. Industry or business.....

12. Name Richard Finley

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

14. Maiden name Rose Lee Miller

15. Birthplace Le Mar Arkansas (City, town, or county) (State or foreign country)

16. (a) Informant M. Geasland
(b) Address 5800 Arsenal St.

17. (a) Cremation (b) Date thereof Sept 10 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City Crematory

18. (a) Signature of funeral director Joseph Ryan

(b) Address City Infirmery

19. (a) SEP 8 1945 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September Day 6
year 1945 hour 1:45 minute P.M.

21. I hereby certify that I attended the deceased from July 2
1945 to September 6, 1945
that I last saw him alive on September 6, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Meningococle
Multiple congenital deformities

Due to.....
Due to..... 157 1/2

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 place) (a) Means of injury

23. Signature Palm Frances Bowditch (M. D. or other) 0
Address City Infirmery Date signed 9-6-45

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.....

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.