

FILED NOV 6 1945

Registration District No. 116

Primary Registration District No. 116-20 3020

Registrar's No. 96

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

1. PLACE OF DEATH:

(a) County FRANKLIN  
(b) City or town Washington Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: ST FRANCIS U  
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County FRANKLIN  
(c) City or town Rural Berger  
(If outside city or town limits, write "RURAL")  
(d) Street No. Main St (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME LOUISA THERESA FINKE

3. (b) If veteran, name war 110 3. (c) Social Security No. NONE

4. Sex FEMALE 5. Color or race White 6. (a) Single, widowed, married, divorced widowed  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased SEPT 29 1870  
(Month) (Day) (Year)

8. AGE: Years 75 Months 0 Days 10 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Gasconade County Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Housekeeper

11. Industry or business HOUSEWIFE

12. Name Daniel Haid  
13. Birthplace UNKNOWN SWITZERLAND  
(City, town, or county) (State or foreign country)  
14. Maiden name Speckels  
15. Birthplace UNKNOWN  
(City, town, or county) (State or foreign country)

16. (a) Informant Henry Finke

(b) Address Berger Mo RFA#1

17. (a) Burial (b) Date thereof 10-17-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ST Johns - Berger Mo

18. (a) Signature of funeral director Paul H. Blum

(b) Address Berger Mo

19. (a) Oct 10 1945 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 9<sup>th</sup>  
year 1945 hour 11 minute 55 P.M.  
21. I hereby certify that I attended the deceased from 10/6/45  
to 10/9/45  
that I last saw her alive on 10/9/45  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral  
the liver Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN [Signature]  
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) (e) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) \_\_\_\_\_

Address Washington Mo Date signed 10/10/45

RECEIVED

District Health Officer No. 9,

District File Number \_\_\_\_\_

Date Filed \_\_\_\_\_

11-5-45

MAY 21 1954

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. 3160

P. O. Address Hermann, Mo

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.