S. No. 2
M—2-43
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I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED NOV 14 1945

State File No. 34592

Registration District No. 317 — Primary Registration District No. 3063 — Registrar's No. 2582

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St Louis County Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 mo - 13 days. (Specify whether
In this community 22 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County St Louis 96
(c) City or town Afton
(If outside city or town limits, write "RURAL")
(d) Street No. 8206 Kanneren
(If rural, give location)
(e) Citizen of foreign country? (~~Yes~~ or No) 1
If yes, name country

3. (a) PRINT FULL NAME George Finger
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 D. B
6. (b) Name of husband or wife Rose Smith
6. (c) Age of husband or wife if alive ? years
7. Birth date of deceased 11 (Month) 5 (Day) 1882 (Year)

8. AGE: Years 63 | Months — | Days 1 | If less than one day ___ hr. ___ min.

9. Birthplace St Louis Missouri
(City, town, or county) (State or foreign country)
10. Usual occupation Roofer
11. Industry or business Virginia Roofing Co
FATHER
12. Name George Finger
13. Birthplace Germany
(City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Marie Klein
15. Birthplace Germany
(City, town, or county) (State or foreign country)
16. (a) Informant Self
(b) Address 8206 Kanneren Afton
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-9-45 (Month) (Day) (Year)
(c) Place: burial or cremation New St Marcus Cem
18. (a) Signature of funeral director J. L. Zeigenhain
(b) Address 7027 Gravois
19. (a) 11-10-45 (Date received local registrar) (b) E. G. McGarrah M.D. (Registrar's signature) NSC

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 6 year 1945 hour 12 minute 30 P.M.
21. I hereby certify that I attended the deceased from 9 24, 1945 to 11 - 6, 1945 that I last saw him alive on 11 - 6, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Post-Op. paralytic ileus.	
Due to 1226	
Due to	
Other conditions Post-operative prostatectomy (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 John T. Farrar (M. D. or other) M.D.
Address 601 Brentwood Date signed 11/6/45

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-13-45

707

(Licensed Embalmer's Statement on Reverse Side) Clayton

NOV 19 1949

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 7027 Gravois

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.