

FILED NOV 29 1945 STANDARD CERTIFICATE OF DEATH 1003

State File No. 35253
Registrar's No. 10107

Registration District No. 318 Primary Registration District No.

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town St. Louis
(c) Name of hospital or institution: 3425 Winnebago St.
(d) Length of stay: In hospital or institution.
In this community years, months or days

3. (a) PRINT FULL NAME Mamie Finke
3. (b) If veteran, name war No.
3. (c) Social Security No.

4. Sex Female / 5. Color or race White
6. (a) Single, widowed, married, divorced, / Married
6. (b) Name of husband or wife J. Herman
6. (c) Age of husband or wife if alive 54 years
7. Birth date of deceased Oct. 21 1893

8. AGE: Years 52 Months 1 Days 0
If less than one day hr. min.

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

10. Usual occupation Home

MOTHER FATHER {
11. Industry or business
12. Name Charles Kamer
13. Birthplace Unknown 9
14. Maiden name Unknown
15. Birthplace Unknown 9

16. (a) Informant J. Herman Finke
(b) Address 3425 Minnesota Ave.

17. (a) (Burial, cremation, or removal) Burial (b) Date thereof Nov. 24, 1945
(Month) (Day) (Year)

(c) Place: burial or cremation Synard Burial Park

18. (a) Signature of funeral director Wacker Helderle
(b) Address 3634 Gravois Ave.

19. (a) NOV 23 1945 J. F. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(d) Street No. 3425 Winnebago St.
(e) Citizen of foreign country? No
If yes, name country

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov. day 21
year 1945. hour 3 minute 30 A. M.
21. I hereby certify that I attended the deceased from Nov. 18 - 45
that I last saw him alive on Nov. 18 - 45
and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of Left Breast which metastasized to Lung
Due to
Other conditions: 50
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations
Of autopsy

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

23. Signature: Joseph E. G...
Address: 406 S. 50th
Date signed: 11/21/45

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

in this count
of the

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..... *Frank J. Phylaud*.....
Licensed Embalmer No..... *2645*.....
P. O. Address..... *St Louis 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.

1945 35253
State File No.

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 10107

1. PLACE OF DEATH:

(a) County St. Louis Mo
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3425 Shinnelago
(If not in hospital or institution, write street number or location)
(d) Place of stay: In hospital or institution _____ (Specify whether _____)
Community _____ (Specify whether _____)
years _____ (Specify whether _____)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 3425 Shinnelago
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Mamie Finke

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex _____ 5. Color or race _____ 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased (Month) _____ (Day) _____ (Year) _____

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

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant J. Herman Finke

(b) Address 3425 Shinnelago St

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____ Year _____
_____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____; that I last saw him _____ and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

PHYSICIAN

Major findings: Of operations _____

Of autopsy _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

USE PENCIL - USE UNPAID INK - MAKE A FERM - RECORD

Send to
H. C. C.