. No. 2
—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 35712

FILED NOV 3 1947

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 9626

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

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis Mo 0
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution City Infirmary Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9/9/47 to 10/15/47 (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 0 00

(c) City or town St. Louis, 17
(If outside city or town limits, write "RURAL")

(d) Street No. 4239 O'Bear 9
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country

10—

3. (a) PRINT FULL NAME Jennie Finn

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widow 2

6. (b) Name of husband or wife John P. Finn,

6. (c) Age of husband or wife if alive widowed years

7. Birth date of deceased Sept, 2, 1878 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
69	1	13	hr. min.

9. Birthplace St. Louis Mo 0
(City, town, or county) (State or foreign country)

10. Usual occupation Nil

11. Industry or business

FATHER
12. Name George Trigg 4
13. Birthplace England 4
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Anna McCabe 4
15. Birthplace Ireland 4
(City, town, or county) (State or foreign country)

16. (a) Informant City Infirmary Records
(b) Address 5800 Arsenal St.

17. (a) Burial (b) Date thereof 10-20-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director [signature]
(b) Address 2117 East Grand Blvd.

19. (a) OCT 17 1947 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct, day 15
year 1947 hour 8 minute 15 M. PM

21. I hereby certify that I attended the deceased from 9/9 1947 to 10/15 1947
that I last saw her alive on 10/15 1947
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebro-multiple ~~Cardio~~ vascular accidents	4 yrs
Due to hemiplegia aphasia	
Due to mental degeneration due to above	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy not obtained

PHYSICIAN
Underline the cause of 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 0

23. Signature A. P. Shorney (M. D. or other)
Address 5600 Arsenal Date signed 10-16-47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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.