

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

38983

State File No.

10891

S. No. 300
V. 10.48

ED DEC 15 1951

318

1003

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (in this place)		2119	
d. FULL NAME OF HOSPITAL OR INSTITUTION City Hospital		d. STREET ADDRESS (If rural, give location) 3859 St. Ferdinand Ave	

3. NAME OF DECEASED (Type or Print)	a. (First) Dolly	b. (Middle) Ann	c. (Last) Finley	4. DATE OF DEATH (Month) (Day) (Year) Dec 7 1951
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 27 1948	9. AGE (In years last birthday) 3	IF UNDER 1 YEAR Months	IF UNDER 12 HRS. Days	IF UNDER 15 MIN. Hours	IF UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis Mo.	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME Thomas Finley	13b. MOTHER'S MAIDEN NAME Lucille Kinworthy	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Thomas Finley	ADDRESS 3859 St. Ferdinand
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute adrenal failure		MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		
	DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	3400	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **12-7-51**, 19____, to **12-7-51**, 19____, that I last saw the deceased alive on **12-7-51**, 19____, and that death occurred at **6:45 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE Robert L. Korn M.D.	(Degree or title)	23b. ADDRESS 1515 Lafayette	23c. DATE SIGNED 12-8-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12/11/51	24c. NAME OF CEMETERY OR CREMATORY Maple Ridge Cemetery	24d. LOCATION (City, town, or county) (State) Carthage Illinois
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DATE REC'D BY LOCAL REG. DEC 8 1951	REGISTRAR'S SIGNATURE J. Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE Sullivan Funeral Dir	ADDRESS 2849 N. Pacific
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(Licensed Embalmer's Statement on Reverse Side)

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

#

White

10-16-51

ENC

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.....

..... Student Embalmer No.
working under my personal supervision.

Student
Student Embalmer

Signed *Robert L. Brinkman*

Licensed Embalmer No. 3533

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.