

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25775

State File No.

FILED JUL 31 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **6955**

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 town or town St. Louis 3		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 8	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 21 3446 Lawton	
d. FULL NAME OF HOSPITAL OR INSTITUTION D.O.A. Homer Phillips			

3. NAME OF DECEASED (Type or Print) Robert	a. (First)	b. (Middle)	c. (Last) Finch	4. DATE OF DEATH (Month) (Day) (Year) July 13, 1952
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5. SEX Male 2	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single 0	8. DATE OF BIRTH April 11, 1909	9. AGE (In years last birthday) 43	IF UNDER 1 YEAR Months	IF UNDER 4 HRS. Days	IF UNDER 15 MIN. Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MORTON, Miss	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Wallace Finch	13b. MOTHER'S MAIDEN NAME Mattie Laster	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Della M. Allen	ADDRESS Roberston Missouri
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchial Asthma		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cardiac Hypertrophy 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	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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4343
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22. I hereby certify that I attended the deceased from 19 to 19, that I last saw the deceased alive on 19, and that death occurred at 4:51 p.m., from the causes and on the date stated above.

23a. SIGNATURE Patrick E. Taylor Coroner	(Degree or title)	23b. ADDRESS 1300 Clark Ave.	23c. DATE SIGNED 7 18 52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 7/19/52	24c. NAME OF CEMETERY OR CREMATORY Washington Park	24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo
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DATE REC'D BY LOCAL REG. JUL 18 1952	REGISTRAR'S SIGNATURE Carl Smith MA	25. FUNERAL DIRECTOR'S SIGNATURE Mose Vasser	ADDRESS 2812 Cass Ave.
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(Licensed Embalmer's Statement on Reverse Side)

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

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 *Leroy W. Barnister*

Licensed Embalmer No. 4523

P. O. Address 3880 Easton Ave.

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.