

FILED OCT 27 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **34740**  
Registrar's No. **8927**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <b>St. Louis, Missouri</b> ) c. LENGTH OF STAY (in this place) <b>7 Days</b>		c. CITY OR TOWN <b>Velda/Village</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Missouri Baptist Hosp.</b>		e. STREET ADDRESS (If rural, give location) <b>6705 Myron ave.</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>William</b>	b. (Middle) <b>Edward</b>	c. (Last) <b>Finney</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Oct. 12, 1955</b>
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5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Sept 9, 1892</b>	9. AGE (In years last birthday) <b>63</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	IF UNDER 1 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supt.-Brake Division</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Wagner Electric</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Springfield Kentucky</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Lafayette Finney</b>	13b. MOTHER'S MAIDEN NAME <b>Elizabeth L. Slyney</b>	14. NAME OF HUSBAND OR WIFE <b>Annabelle L. Finney</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>492-03-0630</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Annabelle L. Finney 6705 Myron ave.</b>
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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, asthma, 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) <b>Coronary Occlusion</b>		<b>7 days</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c)		<b>and years</b>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<b>4200</b>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>4200</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) m.	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 **Oct 7, 1955**, to **Oct 12, 1955**, that I last saw the deceased alive on **Oct 12, 1955**, and that death occurred at **7:30 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>James A. Anderson M.D.</b>	23b. ADDRESS <b>114 No. Taylor St. Louisville</b>	23c. DATE SIGNED <b>10/12/55</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>10-15-55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Cave Hill Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Louisville Kentucky</b>
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DATE REC'D BY LOCAL REG. <b>OCT 13 1955</b>	REGISTRAR'S SIGNATURE <b>J. C. ...</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>G.R. Lupton and Sons 7233 Delmar Blv'd.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1050 - 1 15 5 P.M.

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.....  
Signature of Student Embalmer

Signed *Clarence H. Murr*.....

Licensed Embalmer No. *4011*.....

P. O. Address *St. Louis*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.