

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-024055

STATE FILE NUMBER

FILED JUN 16 1958

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 1464

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>St. Louis</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Richmond Heights</b>              |  | c. CITY OR TOWN <b>Clayton</b> <b>4452<sup>C</sup></b>   |  |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Mary's Hospital</b> |  | d. STREET ADDRESS (If outside, give location) <b>7542 Wydown</b>   |  |
| Length of stay in 1b <b>1 day</b>  |  | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |  |

|   |                               |   |  |   |  |  |
|---|-------------------------------|---|--|---|--|--|
| 3. NAME OF DECEASED (Type or print)<br>First <b>Charles</b> Middle <b>A.</b> Last <b>Finn</b>                           |                               |   | 4. DATE OF DEATH<br>Month <b>May</b> Day <b>29th.</b> Year <b>1958</b> |   |  |  |
| 5. SEX<br><b>M.</b>   | 6. COLOR OR RACE<br><b>W.</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>March 29th. 1902</b>                            | 9. AGE (In years last birthday)<br><b>56</b>                            | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Branch Counsel</b>    |                               | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Transit Casualty</b>  |  | 11. BIRTHPLACE (City and state or country)<br><b>St. Louis Missouri</b> |  |  |
| 13. FATHER'S NAME<br><b>William Finn</b>  |                               |   | 14. MOTHER'S MAIDEN NAME<br><b>Kathryn Murray</b>                      |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)<br><b>no</b> |                               | 16. SOCIAL SECURITY NO.<br><b>UNK.</b>  |  | 17. INFORMANT Address<br><b>Mrs. Naomi Finn 7542 Wydown</b>             |  |  |

|  |  |  |  |
|--|--|--|--|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Reinstated Aneurysm of Aortic arch</b> |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 1/2 hrs</b>   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.   |  |  |  |
| DUE TO (c) <b>Atherosclerosis 451X</b>   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |

|   |  |  |  |  |                                    |
|---|--|--|--|--|------------------------------------|
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>   |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |  |                                    |
| 20c. TIME OF INJURY<br>Hour <b>3:30</b> Month <b>1/10</b> Day <b>50</b> Year <b>58</b><br>a. m. p. m.   |  |  | 20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)    |  |                                    |
| 20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 20f. CITY, TOWN, OR LOCATION COUNTY STATE<br><b>St. Louis Missouri</b>                       |  |                                    |
| 21. I attended the deceased from <b>1/10/58</b> to <b>1/20/58</b> and last saw <sup>him</sup> <b>live</b> on <b>1/20/58</b><br>Death occurred at <b>3:30 p. m.</b> on the date stated above; and to the best of my knowledge, from the causes stated. |  |  |  |  |                                    |
| 22a. SIGNATURE (Degree or title)<br><b>O. J. Fuch M.D.</b>  |  |  | 22b. ADDRESS<br><b>18 S. Kingshighway</b>  |  | 22c. DATE SIGNED<br><b>1/31/58</b> |

|   |  |                              |   |   |  |  |
|---|--|------------------------------|---|---|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>                     |  | 23b. DATE<br><b>6-2-1958</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Calvary Cemetery</b> |   | 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis Missouri</b> |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Br. Thos. J. Donnelly 3840 Lindell Blvd.</b> |  |                              | 25. DATE RECD. BY LOCAL REG.<br><b>5-31-58</b>                | 26. REGISTRAR'S SIGNATURE<br><b>Herbert R. Donke M.D.</b> |  |  |

(Licensed Embalmer's Statement on Reverse Side)

Health, & Welfare Public Service

300 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

St. John's Hosp. of La.

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 *Francis Williamson*

Licensed Embalmer No. *350*

P. O. Address *3840 Le...*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.