

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-026935
STATE FILE NUMBER
6192

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6192

FILED JUL 18 1958

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>St. Louis</u> <u>Normandy</u> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis Little Rock Hosp., Inc.</u> | | Length of stay in lb <u>life</u> | d. STREET ADDRESS (If outside, give location) <u>7025 Glenmore Ave.</u> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Ollie(Oliver) Louis Fink</u> | | 4. DATE OF DEATH Month Day Year <u>June 16 1958</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>March 15, 1900</u> |
| 9. AGE (In years at birthday) <u>58</u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u> | 11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>Louis Fink</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>Amelia Seibert</u> | | 14. NAME OF DECEASED'S WIFE <u>Ann Fink</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>702-14-2348</u> | |
| 17. INFORMANT <u>Mrs. Ann Fink, 7025 Glenmore Ave</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> | | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Heart Disease</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| DUE TO (c) <u>420-0</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | |
| 20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Hour Month, Day, Year a.m. p.m. | | 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | |
| 21. I attended the deceased from <u>June 14, 1958</u> to <u>June 16, 1958</u> and last saw him alive on <u>June 16, 1958</u> Death occurred at <u>3:32 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <u>[Signature]</u> (Degree or title) | | 22b. ADDRESS <u>1755 S. Grand Ave.</u> | |
| 22c. DATE SIGNED <u>6-16-58</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>June 18, 1958</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u> | |
| 24. FUNERAL DIRECTOR <u>Beiderwieden Funeral Home</u> <u>1936 St. Louis Avenue</u> | | 25. DATE RECD. BY LOCAL REG. <u>JUN 18 1958</u> | |
| 26. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | |

color, colorer, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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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 _____

Licensed Embalmer No. 4520
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.