

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-045639
STATE FILE NUMBER

FILED JAN 12 1959

Registration District No. 318

Primary Registration District No. 1003

Registered No. 12752

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1120 Kentucky		d. STREET ADDRESS (If outside, give location) 1120 Kentucky	
3. NAME OF DECEASED (Type or print) First Middle Last ALMEDA FINLEY		4. DATE OF DEATH Month Day Year 12 31, 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-3-1878
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Indiana
13a. FATHER'S NAME James Williams		13b. MOTHER'S MAIDEN NAME Cook	14. NAME OF HUSBAND OR WIFE John Finley
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT 1120 Kentucky Rosamond Moore St. Louis, Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Bronchial Pneumonia DUE TO (b) Arterio Sclerotic Heart Disease DUE TO (c) Chronic Myocarditis with Decompenation PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 420.0			INTERVAL BETWEEN ONSET AND DEATH 2 Days Several yrs 6 mo
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 Hour Month, Day, Year a.m. p.m. —		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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 2/22/58 and last saw her alive on 12/31/58 Death occurred at 8:30 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Hugh Hayes MD		22b. ADDRESS 3720 Washington	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 1-3-59	
23c. NAME OF CEMETERY OR CREMATORY Moores Cemetery		23d. LOCATION (City, town, or county) (State) Mosille, Mo.	
24. FUNERAL DIRECTOR Aker, St. Louis, Mo.		25. DATE RECD. BY LOCAL REG. JAN 2 '59	
26. REGISTRAR'S SIGNATURE J. Carl Smith MD (H.T.)			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 M. Billo*

Licensed Embalmer No. *4375*

P. O. Address *St. Louis, Mo.*

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.