

COURT DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-042392
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11276

AMENDED

FILED DEC 12 1961

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u> | | c. CITY OR TOWN <u>St. Louis</u> | |
| Length of stay in 1b <u>36 Years</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>6936 Bradley</u> | | d. STREET ADDRESS (If outside, give location) <u>6936 Bradley</u> | |
| Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Lillie Smith Finley</u> | | | 4. DATE OF DEATH Month Day Year <u>December 3 1961</u> | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>6-6-1882</u> | 9. AGE (last birthday) <u>79</u> | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | | 11. BIRTHPLACE (City and state or country) <u>Mo</u> | |
| 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | 13a. FATHER'S NAME <u>Moses A. Smith</u> | | 13b. MOTHER'S MAIDEN NAME <u>Amanda Jones</u> | |
| 14. NAME OF HUSBAND OR WIFE <u>William H. Finley</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>None</u> | |
| 17. INFORMANT <u>Mr Floyd Finley 6936 Bradley</u> | | Address | | | |

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Hypertensive Encephalopathy</u> | | | <u>5 mos</u> |
| DUE TO (b) <u>Cerebral arteriosclerosis</u> | | | <u>1 year</u> |
| DUE TO (c) <u>334x</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Hypertensive arteriosclerotic Heart Disease</u> | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |

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|---|--|----------------------------------|--|--|---|
| 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 Hour a.m. p.m. Month, Day, Year | 20d. INJURY OCCURRED WHILE AT WORK <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 July 17, 1961 to Dec. 3, 1961 and last saw her her alive on Nov. 29, 1961
Death occurred at 8 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) <u>Walter A. P. Hill M.D.</u> | | 22b. ADDRESS <u>7346 Manchester Maplewood 17, Mo.</u> | | 22c. DATE SIGNED <u>12-4-61</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal (Auto)</u> | 23b. DATE <u>12/6/61</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Steelville Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Steelville Missouri</u> | |

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| 24. FUNERAL DIRECTOR <u>Alexander & Sons 6175 Delmar Blvd</u> | | 25. DATE RECD. BY LOCAL REG. <u>DEC 4 1961</u> | 26. REGISTRAR'S SIGNATURE <u>Loan Smith M.D.</u> |
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. F. A. Dill

7346a. Manchester Ave

1 to 4 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

Joseph McCulloch

Licensed Embalmer No. 2421

P. O. Address 6140 Rd.

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.