

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-025856

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **6509**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUN 28 1963

1. PLACE OF DEATH a. COUNTY ST LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY ST LOUIS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST LOUIS		Length of stay in 1b 16 DAYS	c. CITY OR TOWN SYCAMORE
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION MO BAPTIST		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2475 HARTLAND
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First NANCY Middle M Last FINLEY			4. DATE OF DEATH Month 6 Day 20 Year 63			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1-4-1894	9. AGE (last birthday) 69	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (City and state or country) WINFIELD MO		
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME CHARLES F. MILLER		13b. MOTHER'S MAIDEN NAME CATHERINE BIRKHEAD		
14. NAME OF HUSBAND OR WIFE DR F. L. 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. [REDACTED]		
17. INFORMANT DR F. L. FINLEY		Address 2475 HARTLAND				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure DUE TO (b) Cerebrovascular accident DUE TO (c) Arteriosclerotic heart disease Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 1 hr 16 da 2 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 420.0		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	

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 1962 to death and last saw her ^{her} alive on 19 June 1963 Death occurred at 7:15 am on the date stated above, and to the best of my knowledge from the causes stated.			
22a. SIGNATURE (Degree or title) Paul R. Whiteaker M.D.		22b. ADDRESS 8923 Midland, St. Louis (14) Mo	22c. DATE SIGNED 20 June 1963
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 6-22-63	23c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK	23d. LOCATION (City, town, or county) (State) ST LOUIS MO MO
24. FUNERAL DIRECTOR Paul Hillman		Address 9709 Locust	25. DATE RECD. BY LOCAL REG. JUN 21 1963
26. REGISTRAR'S SIGNATURE Paul Smith, M.D.			

VS 300 Rev. 4/59
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68
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 ITEM NO. SHOULD READ
 INSTEAD OF
 DOCUMENT
 BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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

Carl F. Hillier

Licensed Embalmer No. 3501

P. O. Address Portland (47th)

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.