

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

40912

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. 6-3889
 Township New Primary Registration District No. St. Joseph Hospital Registered No. 3289
 City St. Louis (No. St. Joseph Hospital) Ward

2. FULL NAME

William Flannagan
 (a) Residence. No. Commonwealth Hotel (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 15 1887
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 47 10 15

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Salesman
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Linn
 (STATE OR COUNTRY) Mo.

10. NAME OF FATHER Wm Flannagan

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) Ireland

12. MAIDEN NAME OF MOTHER Katherine Moran

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Osage city
 (STATE OR COUNTRY) Mo.

14. INFORMANT Betty Flannagan
 (Address) St Louis Mo

15. FILED 4329 Maryland ave
20, 1928 M.M. Crowe REGISTRAR
Assr

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-20-1928
 17. I HEREBY CERTIFY, That I attended deceased from 12-19, 1928, to 12-20, 1928, and that I last saw him alive on 12-19-28, and that death occurred, on the date stated above, at 12:30 A.M.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Cardiac Dehydration
93C
95R (duration) yrs. mos. 2 da.
 CONTRIBUTORY Fibrinous Myocarditis
 (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____
 WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Examination
 (Signed) S. S. M. Frankhaus, M. D.
7/20, 1928 (Address) 405 W. 4th St

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL St Louis Mo DATE OF BURIAL 12/20 1928

20. UNDERTAKER O. Mast ADDRESS 115 Park

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED BY THE OFFICE OF THE STATE ARCHIVIST

