

REC'D AUG 11 1939

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

25059
Do not use this space.

1. PLACE OF DEATH

(a) County Buchanan 2 Registration District No. 85
(b) Township Primary Registration District No. 1001
(c) City St. Joseph (d) Street No. 2802 20 23 St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred 9 yrs. mos. da. (f) How long in U.S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

MARY - FLANAGAN
(a) Residence, No. 2802 20 23 St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 23 1874
7. AGE YEARS 65 MONTHS 2 DAYS 20 If LESS than 1 day, hrs. or min.
8. Trade, profession, or particular kind of work done, as Sawyer, bookkeeper, etc. Cook, at home of Little
9. Industry or business in which work was done, as saw mill, bank, etc. Home of Little
10. Date deceased last (month and year) Aug 6 1938 Total time (years) spent in this occupation 8 1/2
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Irish Iowa
13. NAME Patrick Kennedy
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland
15. MAIDEN NAME Illinois Cook
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois
17. INFORMANT (ADDRESS) Mrs Lillie Nelson 2802 20 23
18. BURIAL, CREMATION, OR REMOVAL PLACE Quilford 7/15/39
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Roy Plummer St. Joseph
20. FILED 7/14 1939 H. M. Whitehair Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 13 1939
22. I HEREBY CERTIFY That I attended deceased from Jan 14 1939 to July 13 1939
I first saw her alive on Mar 23 1939. Death is said to have occurred on the date stated above, at 9:55 A.M.
The principal cause of death and related causes of importance were as follows:
Carcinoma Polype Date of onset 53
Other contributory causes of importance:
Name of operation none Date of
What test confirmed diagnosis Physician Was there an autopsy? no
23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury 19.....
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury
24. Was disease or injury in any way related to occupation of deceased? no
If so, specify
(Signed) JR Elliott M. D.
(Address) 801 1/2 Francis St. St. Joseph, Mo.

WHITE-CARNEY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

K. 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.

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.....

John H. Hurley
.....
working under my personal supervision.

Registered Apprentice No.....

Signed *John H. Hurley*
.....

Licensed Embalmer No. *4050*

P. O. Address *2335 St. Joseph*

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 this body is not embalmed, above space should be left blank.

Missouri State Board of Health
STANDARD CERTIFICATE OF DEATH

State File No. 25059
Registrar's No. 726

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County Richmond
(b) City or town St. Joseph
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Mary Flanagan

3. (b) If veteran name was

Mary

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) April 26 1940 (b) J. P. Nestlebruse
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years

20. DATE OF DEATH Month July day 13 year 29 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____ that I last saw him _____ alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of pelvis

Due to _____

Due to No further information

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury _____

23. Signature J. P. Elliott (M. D. or other)

Address _____ Date signed _____

SUPPLEMENTARY

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

MOTHER FATHER

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

S-25059 1939