

SEP 14 1939

791

State File No.

Registrar's No.

7347

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

1003

(a) County.....
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. John's Hospital
(If not in hospital or institution, write street number and location)
(d) Length of stay: In hospital or institution 10 days
In this community 60 years
years, months or days (Specify whether)

3. (a) PRINT FULL NAME Thomas Flanigan 452

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Margaret E. Flanigan 6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased January 1, 1861
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>78</u>	<u>7</u>	<u>23</u>	hr. _____ min.

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

10. Usual occupation Retired Salesman
11. Industry or business Singer Sewing Machine Company

MOTHER FATHER
12. Name Michael Flanigan
13. Birthplace Ireland
(City, town, or county) (State or foreign country)
14. Maiden name Bridget Mahon
15. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mary E. Flanigan
(b) Address 4925 Nottingham Avenue

17. (a) Burial (b) Date thereof Aug. 28, 1939
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director W. J. Robert
(b) Address 1905 So. Grand Blvd.

19. (a) AUG 25 1939 (b) J. P. Brubaker
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis 14
(If outside city or town limits, write "RURAL")
(d) Street No. 4925 Nottingham Avenue
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 60 year years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 24,
year 1939 hour 11 minute 05 A.M.

21. I hereby certify that I attended the deceased from Aug 6, 1939, to Aug 24, 1939,
that I last saw her alive on Aug 24, 1939,
and that death occurred on the date and hour stated above.

Immediate cause of death
Gastric Hemorrhage 12 hr.
Due to Carcinoma of Stomach 1 yr.
Due to _____

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 Upholster M. P. Robert (M. D. or other)
Address 806 Missouri Bldg Date signed 8-25-39

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

W. J. Robert

Licensed Embalmer No.....

502

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