DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31272

REC'D OCT 1 1939

Registration District No. 791 | Primary Registration District No. | Registrar's No. 8335

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: BARNES HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County NR

(c) City or town Mount Vernon
(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

3. (a) PRINT FULL NAME Ora Odel Flannigan

3. (b) If veteran, name war

3. (c) Social Security No. unk

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Margaret

6. (c) Age of husband or wife if alive 17 years

7. Birth date of deceased Nov. (Month) 5 (Day) 1916 (Year)

8. AGE: Years 22 | Months 10 | Days 22 | If less than one day hr. min.

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

10. Usual occupation Laborer

11. Industry or business

MOTHER FATHER

12. Name Howard S. Flannigan

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

14. Maiden name Rose W Sanders

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

16. (a) Informant's own signature Mrs. Margaret Flannigan

(b) Address Mt. Vernon, Ill.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/29/39 (Month) (Day) (Year)

(c) Place: burial or cremation Boyd, Illinois.

18. (a) Signature of funeral director Albert H. Hoppe.

(b) Address 4700 Washington Bl.

19. (a) SEP 28 1939 (Date received local registrar) (b) J. Bredick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 27 year 1939 hour 12 minute 59 P. M.

21. I hereby certify that I attended the deceased from Sept 23, 1939, to Sept 27, 1939; that I last saw him alive on Sept. 27, 1939; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

Pulmonary Embolism

Due to

Due to

Other conditions (Include pregnancy within 3 months of death) Bilat lower lobe bronchiectasis

Major findings: Of operations Renal Stone left

Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Henry Hoffner (M. D. or other)

Address BARNES HOSPITAL Date signed 9-28-39

(Licensed Embalmer's Statement on Reverse Side)

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

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.

BOM-5-17-39 Rev. 5-17-39 I X19511

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.....

Licensed Embalmer No.....

P. O. Address.....

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.