

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution St. Lukes Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
Kansas City
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 6017 Forest
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr. day 27
year 1940 hour 3 minute 40 P. M.

21. I hereby certify that I attended the deceased from Apr 25
_____, 1940, to Apr 27, 1940
that I last saw him alive on Apr 27, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death acute Interstitial (Parotid)
obstruction with gangrene
of descending colon + small gut 2da
Due to mesenteric thrombosis

Other conditions Thrombus Peritonitis
(Include pregnancy within 3 months of death)

Major findings: acute Int. Obstruc
Of operations _____
Of autopsy above

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? _____

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

23. Signature Fredrick R. J. J. J.
(M. D. or other) _____
Address 624 P. J. J. J. Date signed Apr 29 40

3. (a) PRINT FULL NAME Joseph Lee FLYNN 45071

3. (b) If veteran, name war _____ 3. (c) Social Security No. 514-03-8179

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased October 20th, 1920
(Month) (Day) (Year)

8. AGE: Years 19 Months 6 Days 7
If less than one day _____ hr. _____ min.

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

10. Usual occupation Clerk

11. Industry or business Wholesale Packing Co

12. Name James V. Flynn

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

14. Maiden name Gladys Reboul

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

16. (a) Informant's own signature James V. Flynn

(b) Address 6017 Forest, Kansas City, Mo.

17. (a) Burial (b) Date thereof 4/30/40.
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Melody McGilley

(b) Address K.C. Mo.

19. (a) April 29, 1940 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

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.

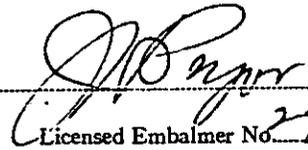
STATEMENT BY LICENSED EMBALMER

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.....


.....

Licensed Embalmer No. 2799

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.