

FILED JUN 25 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

17024

State File No.

Registration District No. 791

Primary Registration District No.

Registrar's No. 4542

1. PLACE OF DEATH:

(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:
Missouri Baptist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULLNAME Cannie Alma Flynn

3. (b) If veteran, name war No 3. (c) Social Security No. _____

4. Sex Female 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 19 1886
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
54 7 9 hr. min.

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

10. Usual occupation Shoemaker
11. Industry or business Shoe Mfg Co.

MOTHER FATHER { 12. Name Warren Flynn
13. Birthplace Jackson () Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Percilla Robertson
15. Birthplace Jackson () Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Beulah D. Flynn
(b) Address 8894 Alva Ave

17. (a) Burial (b) Date thereof May 31/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director [Signature]

(b) Address 1125 Modigmont Ave.

19. (a) MAY 30 1941 (b) [Signature]
(Date of death) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town Carsonville
(If outside city or town limits, write "RURAL")
(d) Street No. 8894 Alva Avenue
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 28
year 1941 hour 9 minute 40 P.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h. ER alive on 5/28/41, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral embolus
Due to auricular fibrillation

Due to Heart disease due to arteriosclerosis

Other conditions (Include pregnancy within 3 months of death)

Major findings: [Handwritten]
Of operations [Handwritten]
Of autopsy [Handwritten]

Duration

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) (c) Means of injury _____

23. Signature [Signature] (M. D. or other) [Signature]
Address 8600 N. Bridge Date signed 5/27/41

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

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17
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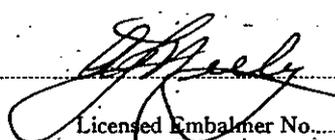
STATEMENT BY LICENSED EMBALMER

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. 3225

P. O. Address 1125 Hodiamont Ave

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, fact should be so stated above.