

V. S. No. 2
 00M-2-43
 Rev. 5-17-39
 I X35687

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

27310

149
 AUG 27 1943

State File No. _____
 Registrar's No. 3593

Registration District No. _____ Primary Registration District No. 1002

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Kansas City
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
3321 Prospect
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community 19 days (Specify whether
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Jackson (b) County Missouri
 (c) City or town Blue Springs
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME John Thomas Flynn
 3. (b) If veteran, name war No 3. (c) Social Security No. 6709-12-1876

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 Feb. 28 1876
 (Month) (Day) (Year)

8. AGE: Years 67 Months 5 Days 22 If less than one day _____ hr. _____ min.

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

10. Usual occupation Pumper

11. Industry or business _____

MOTHER FATHER

12. Name Thomas E. Flynn

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

14. Maiden name Dilla A. Koating
 (City, town, or county) (State or foreign country)

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

16. (a) Informant Mrs. J.E. Farrell

(b) Address 3321 Prospect

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 20 -43
 (Month) (Day) (Year)

(c) Place: burial or cremation Slater Mo.

18. (a) Signature of funeral director Mrs. C. L. Forster

(b) Address 918 Brooklyn Kansas City Mo.

19. (a) 8-20-43 (Data received local registrar) (b) W. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 20 year 1943 hour 5 minute A M.

21. I hereby certify that I attended the deceased from 8/1-1943 to 8/20-1943 that I last saw him alive on 8/19 and that death occurred on the date and hour stated above. 19.43

Immediate cause of death Branchial Pneumonia Duration 2 1/2 hours

Due to chronic myo carditis

Due to _____
 Other conditions (include pregnancy within 3 months of death) 93d

Major findings: Of operations _____
 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? _____

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

23. Signature W. E. Russell (M. D. or other) _____
 Address 3231 E. 11 St. Date signed 8/20/43

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

Dr. D. P. Russell

JAN 31 8. 11

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 Denzil C. Browning

Licensed Embalmer No. 2724

P. O. Address Kansas City 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, fact should be so stated above.