

V. S. No. 2
FORM-2-43
Revised 5-17-39
1 X3587

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29922

State File No.

FILED OCT 13 1943 318
Registration District No.

Primary Registration District No. 1003

Registrar's No. 8602

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: DePaul Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3-days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County St. Louis
(c) City or town Belnor
(If outside city or town limits, write "RURAL")
(d) Street No. 8054 Audrain Drive (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME Michael D. Flavin
3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex M. 5. Color or Race W.
6. (a) Single, widowed, married, divorced M.
6. (b) Name of husband or wife Viola H. Flavin
6. (c) Age of husband or wife if alive 54 years
7. Birth date of deceased Aug. 22nd., 1883 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
60 1 5 hr. min.

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

10. Usual occupation Salesman

11. Industry or business Mut. Benefit L. Ins. Co.

12. Name James Flavin

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

14. Maiden name Catherine McGrath

15. Birthplace St. Louis Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Viola H. Flavin

(b) Address 8054 Audrain Drive

17. (a) Burial (b) Date thereof 9-30-43 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Arthur J. Konnette
(b) Address 7840 Lindell Blvd.

19. (a) SEP 29 1943 (Date received local registrar) J. F. [Signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 27th., year 1943 hour 12 minute noon M.

21. I hereby certify that I attended the deceased from July 2 1943 to Sept 27 1943 that I last saw him alive on Sept 26 1943 and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of [unclear] Bronchus

Due to: Chronic Bronchitis

Other conditions: (Include pregnancy within 3 months of death) H7

Major findings: Of operations
Of autopsy

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?

23. Signature [Signature] (Specify type of place) (M. D. or other)
Address 7301 [unclear] Date signed 9-28-43

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

MOTHER, FATHER

W
H

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. H. Van Matre

Licensed Embalmer No. 2825

P. O. Address 4340 Lafayette

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.