V. S. No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 18 1944

Registration District No. 317

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 31719

Primary Registration District No. 3063

Registrar's No. 1906

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

1. PLACE OF DEATH

(a) County St Louis

(b) City or town Clayton (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution St Louis County Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 days (Specify whether years, months or days)

In this community 25 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St Louis 96

(c) City or town Ventia Park (If outside city or town limits, write "RURAL")

(d) Street No. 8316 Washington (If rural, give location)

(e) Citizen of foreign country? (Yes or No) /

If yes, name country

3. (a) PRINT FULL NAME Elizabeth Flynn

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife Peter Flynn

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

7. Birth date of deceased Jan. 25. 1869 (Month) (Day) (Year)

8. AGE: Years 75 Months 7 Days 11 If less than one day hr. min.

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

10. Usual occupation —

11. Industry or business —

MOTHER FATHER

12. Name —

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

14. Maiden name —

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

16. (a) Informant self (b) Address 8316 Washington U. Park

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 9, 1944 (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Bernard C. Peckenpaugh

(b) Address 1431 Union Blvd.

19. (a) SEP 9 - 1944 (Date received by local registrar) (b) C. G. McCauran, M.D. (Registrar's signature) A.K.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 5 year 1944 hour 5 45 minute A.M. P.M.

21. I hereby certify that I attended the deceased from Sept 1, 1944 to Sept 5, 1944 that I last saw her alive on Sept 5, 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Arteriosclerotic Cardio-Vascular Disease	—
Due to	
Due to	
Other conditions: Generalized Arteriosclerosis (Include pregnancy within 3 months of death)	—

Major findings:
Of operations
Of autopsy 93d

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 John Niederwimer (M. D. or other) M.D.

Address 601 Bentwood Blvd Date signed 9-5-44 Clayton Mo.

(Licensed Embalmer's Statement on Reverse Side)

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 Howard P. Rowland

Licensed Embalmer No. 3114

P. O. Address St Louis 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.