

FILED NOV 19 1945

1003

Registration District No. 318

Primary Registration District No. _____

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: City Sanitarium
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 19 ds.
In this community 68 yrs.
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 3808 Juniata St.
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME BRIDGET FLYNN

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

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced Sgl.

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

7. Birth date of deceased February 2, 1866
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
79 9 2 _____ hr. _____ min.

9. Birthplace Boston Mass.
(City, town, or county) (State or foreign country)

10. Usual occupation Housework

11. Industry or business _____

MOTHER FATHER { 12. Name Michael Flynn
13. Birthplace Ireland
(City, town, or county) (State or foreign country)
14. Maiden name Jane Maloney
15. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant J. Singler
(b) Address 5400 Arsenal St.

17. (a) Burial (b) Date thereof 10/7/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cape May, N.J.

18. (a) Signature of funeral director Southside Funeral Home

(b) Address 6322 S. Grand Blvd.

19. (a) NOV 6 1945 (b) J. F. Brodeur
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 4.
year 1945 hour 10.15 minute A M.

21. I hereby certify that I attended the deceased from Oct. 15, 1945 to Nov. 4, 1945, that I last saw her alive on Nov. 4, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death _____
Due to Cardiac Decompensation 10/15/45

Due to Senile debility 1945x

Other conditions _____
(Include pregnancy within 3 months of death)

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 C. J. M. Tammelle (M. D. or other) M.D.
Address 5400 Arsenal Date signed 11/14/45

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

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. G. Peterson*.....

Licensed Embalmer No. *3767*.....

P. O. Address *Duvalburg 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.