

No. 300
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FEDERAL SECURITY AGENCY

National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

31635

FILED OCT 4 1948

Registrar's No. 2072

Registration District No. 27

Primary Registration District No. 6576

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Lemay
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Mt. St. Rose Sanatorium
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howell 46
(c) City or town Willow Springs 2
(If outside city or town limits, write "RURAL") 0
(d) Street No. _____ (If rural, give location) 1
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 1
year 1948 hour 3 minute 20 A.M.

21. I hereby certify that I attended the deceased from 8/12, 1948, to 9/1, 1948,
that I last saw him alive on 8/31, 1948,
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary tuberculosis 2 yrs
Duration

Due to 13 hr
Due to _____

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?
_____ (Specify type of place) _____ (e) Means of injury _____

While at work? _____
23. Signature [Signature] (M. D. or other) MD
Address 634 N. Spruce Date signed 9/1/48

3. (a) PRINT FULL NAME William Norbert Flannery

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Reva Flannery 6. (c) Age of husband or wife if alive 38 years

7. Birth date of deceased: March 21 1904
(Month) (Day) (Year)

8. AGE: Years 44 Months 5 Days 11 If less than one day _____ hr. _____ min.

9. Birthplace DeWitt Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation Tree Surgery

11. Industry or business _____

12. Name Michael T. Flannery

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

14. Maiden name Margaret Spellis

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

16. (a) Informant Reva Flannery

(b) Address Willow Springs, Mo.

17. (a) Removal (b) Date thereof 9-2-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation DeWitt, Iowa.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) 9-1-48 (b) [Signature]
(Date received local registrar) (Registrar's signature)

OCT 4 1948

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..... *Frank J. Landro*
Licensed Embalmer No. *2645*
P. O. Address..... *St. Landro*

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.