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FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED NOV 19 1948

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 38111

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9660

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

1. PLACE OF DEATH:

(a) County

(b) City or town St.Louis,Missouri.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St.Louis City Hospital-Max C.Starkloff
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 0 (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St.Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. Annex Hotel- 615 Walnut 9
Memorial 25 (If rural, give location) 0

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

If yes, name country

3. (a) PRINT FULL NAME JOSEPH FLYNN

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex male 0

5. Color or race white

6. (a) Single, widowed, married, divorced single 0

6. (b) Name of husband or wife

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

7. Birth date of deceased Feb. - 1873
(Month) (Day) (Year)

8. AGE: Years 75 Months 9 Days - If less than one day hr. min.

9. Birthplace St.Louis, Missouri 0
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business

FATHER
12. Name James Flynn
13. Birthplace Ireland 4
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Ann Cosgrove
15. Birthplace Ireland 4
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs.Stephen W.Heckemeyer
(b) Address 3726 Slyvan Place

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 11-6-48
(Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemtery

18. (a) Signature of funeral director Jos.W.Clark
(b) Address 1125 Hodiamont Ave.

19. (a) NOV 6 1948 (Date received local registrar) (b) J. B. Lasater (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 6th
year 1948 hour 2 minute 50 A M.

21. I hereby certify that I attended the deceased from 9/30/48
, 19 , to Nov. 6th , 1948
that I last saw him alive on Nov. 6th , 1948
and that death occurred on the date and hour stated above.

Immediate cause of death
pulmonary tuberculosis, far advanced

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration
unknown

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? Frank J. Martin (e) Means of injury 0

23. Signature 1515 Lafayette 11/6/48 (M. D. or other)

Address Date signed

(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 No Embalming, Registered Apprentice No. ....., working under my personal supervision.

Signed Jos. W. Clark

Licensed Embalmer No. 1661

P. O. Address .....

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.