

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36647

State File No.

BIRTH NO. _____ REG. DIST. NO. 71 PRIMARY REG. DIST. NO. 8012 Registrar's No. 136

1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Excelsior Springs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>	
c. LENGTH OF STAY (in this place) <u>1 yr 4 mos 26 da</u>		d. STREET ADDRESS (If rural, give location) <u>5507 St. John Ave., K. C. Mo.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Veterans Administration Hospital</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Robert J</u>	b. (Middle)	c. (Last) <u>Flynn</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>November 8, 1949</u>
-------------------------------------	----------------------------	-------------	------------------------	---

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 4, 1906</u>	9. AGE (In years last birthday) <u>43</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
--------------------	-------------------------------	---	--------------------------------------	---	---	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Self Empl.</u>	11. BIRTHPLACE (State or foreign country) <u>Richland, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>US</u>
---	---	--	--

13a. FATHER'S NAME <u>Elmer Flynn</u>	13b. MOTHER'S MAIDEN NAME <u>Hazelle Mary</u>	14. NAME OF HUSBAND OR WIFE <u>Fern Flynn</u>
---------------------------------------	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WWII</u>	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <u>Hospital Records</u>	ADDRESS <u>Excelsior Springs</u>
--	-------------------------------	---	----------------------------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary Tuberculosis</u>	DUE TO (b) <u>Postoperative Pulmonary Insufficiency</u>		<u>14 mo.</u>
ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u>	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>			

19a. DATE OF OPERATION <u>10-14-49</u>	19b. MAJOR FINDINGS OF OPERATION <u>Pulmonary Tuberculosis (Right Upper Lobectomy)</u>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
--	--	--

21a. ACCIDENT : SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
---	--	----------------------------------

22. I hereby certify that I attended the deceased from July 12, 1948 to Nov. 8, 1949, that I last saw the deceased alive on Nov. 8, 1949, and that death occurred at 7:20 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>R. E. Weatheringham, M.D.</u> <u>R. E. WEATHERINGHAM</u>	(Degree or title) <u>M.D.</u>	23b. ADDRESS <u>Excelsior Springs, Mo.</u>	23c. DATE SIGNED <u>11-8-49</u>
---	-------------------------------	--	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>Nov. 8/49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Kansas City, Mo.</u>	24d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>
--	----------------------------	--	---

DATE REC'D BY LOCAL REG. <u>11/8/49</u>	REGISTRAR'S SIGNATURE <u>Caroline Hutchings</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>C. H. Blackman</u>	ADDRESS <u>Kansas City, Mo.</u>
---	---	--	---------------------------------

(Licensed Emballer's Statement on Reverse Side)

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

24
1

RECEIVED

DEC 6

District Health Officer No.

District File Number

Date Filed

12-9-49

DEC 5

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

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed *James A. Moles*

Licensed Embalmer No. 3296

P. O. Address *Ex Springs, W.*

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.