

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-005011

STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 87

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAR 12 1963

VS 300
Rev. 4/59

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20017

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Adair | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Adair | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirksville | | Length of stay in 1b yrs. | c. CITY OR TOWN Kirksville Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Laughlin Hosp. | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 711-N-High Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) JOHN T. FLYNN | | First Middle Last | 4. DATE OF DEATH Month March Day 3 Year 1963 |
| 5. SEX male | 6. COLOR OR RACE white | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 12-17-86 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacist | | 10b. KIND OF BUSINESS, OR INDUSTRY Druggist | 9. AGE (last birthday) 76 IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HR: Months _____ Days _____ Hours _____ Min. _____ |
| 11a. BIRTHPLACE (City and state or country) Adair County, Mo. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME John Flynn | | 13b. MOTHER'S MAIDEN NAME Bridget Quinn | |
| 14. NAME OF HUSBAND OR WIFE | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of _____) | |
| 16. SOCIAL SECURITY NO. 25 | | 17. INFORMANT Mrs. John Flynn, Kirksville, Mo Address _____ | |
| 18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. AURICULAR FIBRILLATION ACUTE INFLUENZA & BRONCHITIS 1 WEEK DUE TO (b) _____ DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH 5 MIN UNKNOWN 1 WEEK | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____ | | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____ | |
| 21. I attended the deceased from 3-1-63 to 3-3-63 and last saw him alive on 3-3-63 Death occurred at 7:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) Paul Laughlin D.D. | | 22b. ADDRESS KIRKSVILLE, Mo | |
| 22c. DATE SIGNED 3-6-63 | | 23. LOCATION (City, town, or county) (State) Kirksville, Mo. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE 3-7-1962 | 23c. NAME OF CEMETERY OR CREMATORY Highland Park Cem. Kirksville, Mo. | |
| 24. FUNERAL DIRECTOR Davis & Davis, Kirksville, Mo. ADDRESS _____ | | 25. DATE RECD. BY LOCAL REG. 3-8-1963 | |
| 26. REGISTRAR'S SIGNATURE Doris W. Ratliff | | 27. _____ | |

USE BLACK INK OR TYPEWRITER RIBBON

MAR 13 1963

APR 16 1963

MAY 7 1963

EARL LAUCKLIN, JR. D.O.

No permit issued

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 _____

Signature of Student Embalmer

Signed Robert B. Davis

Licensed Embalmer No. 4219

P. O. Address Kirksville, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.