

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-019717

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 835

VS 300
Rev. 4/59

1 0397
2 0397
3
4 0
5 1
6
7 0
8 2
2332 X

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

DOCUMENT

1. PLACE OF DEATH a. COUNTY <u>GREENE</u>		2. USUAL RESIDENCE (Where deceased lived: If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>GREENE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SPRINGFIELD</u>		Length of stay in 1b	c. CITY OR TOWN <u>SPRINGFIELD</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BURGE HOSPITAL</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1423 CONCORD</u>
3. NAME OF DECEASED (Type or print) First <u>ALFRED</u> Middle <u>T.</u> Last <u>FLANAGAN</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>29</u> Year <u>1963</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5-19-1874</u>
9. AGE (last birthday) <u>89</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GROCERYMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	11. BIRTHPLACE (City and state or country) <u>MISSOURI</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>W.J. FLANAGAN</u>	
13b. MOTHER'S MAIDEN NAME <u>MARY McALISTER</u>		14. NAME OF HUSBAND OR WIFE <u>ADA FLANAGAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		17. INFORMANT <u>ADA FLANAGAN (WIFE)</u>	
16. ADDRESS <u>SPRINGFIELD, MO</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:	
IMMEDIATE CAUSE (a) <u>Cerebral vascular thrombosis with left hemiplegia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
DUPLICATE (b) <u>Arteriosclerosis, generalized.</u>			
DUPLICATE (c)			
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 <u>5-21-63</u> to <u>5-29-63</u> and last saw ^{her} him alive on <u>5-29-63</u>		Death occurred at <u>4:00</u> <u>A</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>Paul P. Norton</u> (degree or title)		22b. ADDRESS <u>M.D. 1630 N. Jefferson, Spgg., Mo</u>	22c. DATE SIGNED <u>5-29-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>6-1-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CLEAR CREEK CEME.</u>	23d. LOCATION (City, town, or county) (State) <u>GREENS COUNTY Mo.</u>
24. FUNERAL DIRECTOR <u>KLINGNER MORTUARY</u>	ADDRESS <u>SAGFD. Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>5-31-1963</u>	26. REGISTRAR'S SIGNATURE <u>Effie G. Melton</u>

USE BLACK INK OR TYPEWRITER RIBBON

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

WV 10-887

STATEMENT BY LICENSED EMBALMER

5-29

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 Alan D. Williams

Licensed Embalmer No. 4651

P. O. Address Springfield 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.