

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH.

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-020076

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2839 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB
 AMENDED

VS 300
 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 25 yrs	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Research Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1335 Askew Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Frank Middle Flynn Last Flynn			4. DATE OF DEATH Month May Day 17 Year 1963
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5-31-1909
9. AGE (last birthday) 53		IF UNDER 1 YEAR Months 53 Days 0 Hours 0 Min. 0	IF UNDER 24 HR Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Postal Clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.	11. BIRTHPLACE (City and state or country) Buckner, Mo
12. CITIZEN OF WHAT COUNTRY U.S.A		13a. FATHER'S NAME Frank John Flynn	
13b. MOTHER'S MAIDEN NAME Abbie Patty		14. NAME OF HUSBAND OR WIFE Mrs. Abbie Flynn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of servi) No None		16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Abbie Flynn Address 1335 Askew K.C. Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) chronic brain syndrome			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 checked="" 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 April 25, 1955 and last saw him alive on May 16, 1963 Death occurred at 8:20 m on the date stated above, and to the best of my knowledge, from the causes stated.			
22. SIGNATURE G. Kettner (Degree or title)		22b. ADDRESS Kansas City, Mo.	22c. DATE SIGNED May 17, 1963
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5-20-63	23c. NAME OF CEMETERY OR CREMATORY Mt. Washington	23d. LOCATION (City, town, or county) Independence, Mo.
24. FUNERAL DIRECTOR East & Sons. K.C. Mo.		25. DATE RECD. BY LOCAL REG. 5-17-63	26. REGISTRAR'S SIGNATURE [Signature]

USE BLACK INK OR TYPEWRITER RIBBON

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 William H. Carpa

Licensed Embalmer No. 4728

P. O. Address KC, 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.