SEP 24 1957

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

24208

File No. .....

Registered No. .....

32

1. PLACE OF DEATH

County Dekalb. Registration District No. 259

Township Sherman Primary Registration District No. 5361

City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME JOHN RUBEN FLANNAGAN

(a) Residence. No. ..... St. ..... Ward. HELENA, MO.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
MALE	WHITE	MARRIED

5a. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF MARY FLANNAGAN

6. DATE OF BIRTH (MONTH, DAY AND YEAR) JAN. 7, 1858

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	71	6	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work CARPENTER
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) KNOXVILLE.
(STATE OR COUNTRY) IOWA

PARENTS

10. NAME OF FATHER THOMAS FLANNAGAN

11. BIRTHPLACE OF FATHER (CITY OR TOWN) UNKNOWN
(STATE OR COUNTRY) IND.

12. MAIDEN NAME OF MOTHER RACHEL MATHEWS

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) UNKNOWN
(STATE OR COUNTRY) UNKNOWN.

14. INFORMANT Mary Flanagan
(Address) Helena, Mo

15. FILED 7/28, 1929 J. Q. Phelps M.D.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) JULY 27/ 29

17. I HEREBY CERTIFY, That I attended deceased from July 11, 1929, to July 27, 1929, that I last saw h. alive on July 27, 1929, and that death occurred, on the date stated above, at 11:00 A.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Apoplexy
Gall Bladder
Cancer (duration) yrs. mos. 16 ds.

CONTRIBUTORY (SECONDARY) ..... (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED .....
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS .....
(Signed) [illegible], M. D.
7/27, 1929 (Address) King City, Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
GUILFORD CEMETERY	7/28/ 29

20. UNDERTAKER T. D. Wilson ADDRESS King City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD