

23 1931

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

Do not use this space.

4574

1. PLACE OF DEATH

County *Jesse*
Township *Columbia*
City *Columbia*

Registration District No. *73*
Primary Registration District No. *3006*

File No.
Registered No. *28*
St. Ward)

2. FULL NAME

John F. Flynn
(a) Residence No. *Columbia Hotel* Ward.
(Usual place of abode)
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 *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Apr. 18, 1875*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hr. or min.
55 9 18

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Clerk 253*
(b) General nature of industry, business, or establishment in which employed (or employer) *Columbia Hotel*
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Raywood, Mo.*
(STATE OR COUNTRY) *Mo.*

10. NAME OF FATHER *David Flynn*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Jowa*
(STATE OR COUNTRY) *2.*

12. MAIDEN NAME OF MOTHER *Don't know*

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

14. INFORMANT *J. M. Flynn*
(Address) *220 E. 42nd St N.Y. City*

15. FILED *2/9/31* *F. C. Suggett* REGISTRAR
by Selby

1 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Feb 6th 1931*

17. I HEREBY CERTIFY, That I attended deceased *John F. Flynn* on *Feb 6*, 1931, to *X*, 19... and that I last saw h. *Y* alive on *Feb 5*, 19... and that death occurred, on the date stated above, *Feb 6, 1931 at 8:30 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral apoplexy
Sudden death
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED?

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? *no.* DATE OF

WAS THERE AN AUTOPSY? *yes*

WHAT TEST CONFIRMED DIAGNOSIS? *Autopsy*

(Signed) *G. E. Davis, M. D.*

2-7-1931 - (Address) *Columbia 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

Denver, Colorado DATE OF BURIAL *2-10-1931*

20. UNDERTAKER

Tom McHara ADDRESS *Columbia Mo.*

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 ONFADING INK—THIS IS A PERMANENT RECORD

