

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

Do not use this space.

8581

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City, Mo. (No. 399)

Registration District No. 399
Primary Registration District No. 1052
St Joseph Hospital

File No. 1165
Registered No. 1165
St. _____ Ward _____

2. FULL NAME John J. Flynn

(a) Residence, No. 2620 Troost St. _____ 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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Minnie Flynn</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Not Known</u>		
7. AGE YEARS	MONTHS	DAYS
<u>About 75</u>		
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.	<u>City Hall</u>
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.	<u>Street Inspector</u>
	10. Date deceased last worked at this occupation (month and year)	11. Total time (years) spent in this occupation
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>New York</u> <u>2</u>		
FATHER	13. NAME	<u>Not Known</u>
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)	<u>Not Known</u> <u>21</u>
MOTHER	15. MAIDEN NAME	<u>Not Known</u>
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)	<u>Not Known</u>
17. INFORMANT (ADDRESS) <u>Mr C. F. Shinner</u> <u>7201 Virginia</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>St Marys Cemetery</u> DATE <u>Mar 22, 1932</u>		
19. UNDERTAKER (ADDRESS) <u>Wagner Funeral Home</u> <u>204 W. Linwood</u>		
20. FILED <u>3/21</u> 19 <u>32</u> <u>M. M. Crowe</u> <u>Registrar.</u>		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 20, 1932

22. I HEREBY CERTIFY that I attended deceased from _____, 19____.

I last saw him _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at 2: P.M.

The principal cause of death and related causes of importance were as follows:
Robert Johnson
108
108
7

Other contributory causes of importance: _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____.
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____

(Signed) Robert Johnson, M. D.
(Address) _____

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

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.

