

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

35658  
Do not use this space.

**NOV 15 1937**

1. PLACE OF DEATH.....  
 (a) County..... Registration District No. **791**  
 (b) Township..... Primary Registration District No. **1003** Registered No. **9235**  
 (c) City **ST. LOUIS** (d) Street No. **Mo. BAPTIST Hosp.** St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **JAMES FLAVIN**  
 (a) Residence, No. **4900 FOUNTAIN AVE** St. **12**  
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX **M** 4. COLOR OR RACE **W.** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Widowed**  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or WIFE OF) **KATE FLAVIN**  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **SEPT. 21, 1856**  
 7. AGE YEARS **81** MONTHS **0** DAYS **10** If LESS than 1 day, ..... hrs. or ..... min.  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **RETIRED**  
 9. Industry or business in which work was done, as saw mill, bank, etc. **BUILDING CONT.**  
 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) **IRELAND**  
 FATHER 13. NAME **MICHAEL FLAVIN** 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **IRELAND**  
 MOTHER 15. MAIDEN NAME **MARY RILEY** 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **IRELAND**  
 17. INFORMANT **Wm FLAVIN**  
 (ADDRESS) **4900 FOUNTAIN AVE**  
 18. BURIAL, CREMATION, OR REMOVAL PLACE **CALVARY** DATE **OCT. 4 1937**  
 19. FUNERAL DIRECTOR **CROGHAN UND. CO. INC.**  
 (ADDRESS) **7146 MANCHESTER**  
 20. FILED **OCT 2 1937** Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**  
 21. DATE OF DEATH (MONTH, DAY AND YEAR) **Oct 1 1937**  
 22. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....  
 I last saw h..... alive on..... 19..... Death is said to have occurred on the date stated above, at **3:30 p.m.**  
 The principal cause of death and related causes of importance were as follows:  
**Shock Laceration and injuries to head the cause and manner could not be ascertained**  
 Date of onset  
 Other contributory causes of importance:  
**arteriosclerosis**  
 Name of operation..... Date of.....  
 What test confirmed diagnosis?..... Was there an autopsy? **no**  
 23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? **gunshot** Date of injury **last seen**  
 Where did injury occur? **St. Louis Mo** (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.  
 Manner of injury **see above**  
 Nature of injury.....  
 24. Was disease or injury in any way related to occupation of deceased?  
 If so, specify **Alfred J. Ferris M.D.**  
 (Signed) **Deputy Coroner**  
 (Address).....

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.

5-15-15 0009

STATEMENT BY LICENSED EMBALMER

I, M. J. Croghan, Licensed Embalmer No. 2622

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

..... L. E. ....

No. .... or by ..... Registered Apprentice No. ....  
working under my personal supervision.

Signed M. J. Croghan  
Licensed Embalmer No. 2622

**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.)**