

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.

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1939 APR 7 1939

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

12337  
Do not use this space.

1. PLACE OF DEATH  
(a) County St. Louis Registration District No. 784  
(b) Township University City Primary Registration District No. 115 Registered No. 403  
(c) City University City (d) Street No. 515 West Point 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 Nellie Layton Flynn  
(a) Residence, No. # 515 West Point St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 29 - 1863

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ..... hrs. or ..... min.
	<u>75</u>	<u>11</u>	<u>5</u>	

OCCUPATION  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as saw mill, bank, etc. At Home  
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) Old Orchard, Mo.

FATHER  
13. NAME Frank Layton  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Virginia

MOTHER  
15. MAIDEN NAME Alice Badger  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Parsyck, Ky.

17. INFORMANT (ADDRESS) J. D. Eby, # 515 West Point Dr.

18. BURIAL, CREMATION, OR REMOVAL PLACE Lake Charles DATE 3-6-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) C. R. Layton & Sons, # 7233 Belmont Ave.

20. FILED MAR 5 1939 J. H. Meyer, M.D., Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 5, 1939

22. I HEREBY CERTIFY, That I attended deceased from Jan 26, 1939, to Mar 5, 1939  
I last saw her alive on Mar 5, 1939. Death is said to have occurred on the date stated above, at 7 A.M.  
The principal cause of death and related causes of importance were as follows:  
Chronic Intestinal Vephrta Date of onset 131

Other contributory causes of importance:  
Arteriosclerosis

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? Yes

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) Ralph E. Layton, M. D.  
(Address) Wichita, Kansas, Mo.

#17  
S-9 R. M.  
Lockwood  
Metropolitan  
Bureau

**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed Clarence H. Murray

Licensed Embalmer No. 4011

P. O. Address St. Louis, 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 this body is not embalmed, above space should be left blank.