

30 JUL 11 1939

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

21625
Do not use this space.

1. PLACE OF DEATH
 (a) County Buchanan Registration District No. 85
 (b) Township..... Primary Registration District No. 1001
 (c) City St. Joseph (d) Street No. 715 South 16th. 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 65 yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 452 Leonida Flanigan.
 (a) Residence, No. 715 S. 16th. St. (If nonresident, give city or town and State)

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 Flanigan

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) October 1, 1865.

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>73</u>	<u>8</u>	<u>28</u>	

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. At home
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation ?

12. BIRTHPLACE (CITY OR TOWN) Omaha
 (STATE OR COUNTRY) Nebraska

FATHER
 13. NAME Maximilian Marcinkowski
 14. BIRTHPLACE (CITY OR TOWN) Unknown
 (STATE OR COUNTRY) Poland

MOTHER
 15. MAIDEN NAME Margaret O'Brien
 16. BIRTHPLACE (CITY OR TOWN) Unknown
 (STATE OR COUNTRY) Ireland

17. INFORMANT Mrs. C.E. Toole
 (ADDRESS) 715 S. 16th. Str. St. Joseph, Mo.

18. BURIAL, CREMATION, OR REMOVAL Mt. Olivet Cemetery
 PLACE St. Joseph, Mo. DATE July 1, 1939

19. FUNERAL DIRECTOR (NAME) H.O. Sidenfaden & Son
 (ADDRESS) 1802 Union Str. St. Joseph, Mo.

20. FILED June 30 1939 A.J. Decker
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 29, 1939

22. I HEREBY CERTIFY, That I attended deceased from March 10, 1939, to June 29, 1939
 I last saw her alive on June 26, 1939. Death is said to have occurred on the date stated above, at 9:30 A.M.
 The principal cause of death and related causes of importance were as follows:
Paralysis Agitans Date of onset Unknown
ggb

Other contributory causes of importance:
None

Name of operation None Date of None
 What test confirmed diagnosis? Clinical Was there an autopsy? No

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? No
 If so, specify
 (Signed) [Signature], M. D.
 (Address) [Address]

WRITE PAINFULLY, 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.

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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 *Albert C. Harrington*
Licensed Embalmer No. *3258*
P. O. Address *St. Joseph, 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.