

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 784

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: #5 Shaw Place
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. #5 Shaw Place (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Lawrence C. Flynn 450

8. (b) If veteran, name war None 8. (c) Social Security No. None

4. Sex M. 5. Color or race W. 6. (a) Single, widowed, married, divorced M.
6. (b) Name of husband or wife Olive E. Flynn 6. (c) Age of husband or wife if alive 58 years
7. Birth date of deceased Aug. 3, 1874
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
65 5 22 hr. min.

9. Birthplace Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Buyer

11. Industry or business Lumber

12. Name John Flynn

13. Birthplace Ireland
(City, town, or county) (State or foreign country)

14. Maiden name Rose Unknown

15. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Miss Rose Flynn

(b) Address 5401 Maryland Ave.

17. (a) Burial Calvary Cem. (b) Date thereof 1-27-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation 3840 Lindell Blvd.

18. (a) Signature of funeral director J.B. Rudolph
(b) Address _____

19. (a) JAN 26 1940 (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 25th.
year 1940 hour 12 minute 30 P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Cerebral Hemorrhage
secondary to
hypertension
8/2/40

Other conditions (Include pregnancy within 8 months of death) _____

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (Specify means of injury)

23. Signature W. H. Perry (M. D. or other) _____
Address St. Louis, Mo. Date signed 1-26-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FORM 5-17-39 U.S. GPO 16-11391-1

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.

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 W H Van Matre

Licensed Embalmer No. 2825

P. O. Address 4340 Lafayette

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.