No. 2
11-10-39
5-17-39
I X21492

7

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 2461 105

Registration District No. 318 Primary Registration District No. 6440 Registrar's No.

1. PLACE OF DEATH:

(a) County GREENE FILED FEB 13 1940

(b) City or town Springfield, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Medical Center for Federal Prisoners
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 27 days 2 (Specify whether
In this community 27 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Tennessee (b) County

(c) City or town Winfield, Route # 2.
(If outside city or town limits write "RURAL")

(d) Street No. Route # 2.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME FLYNN, Sherman 450

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mrs. Alta Flynn

6. (c) Age of husband or wife if alive 43 years

7. Birth date of deceased April 3, 1885 (Month) (Day) (Year)

8. AGE: Years 54 Months 9 Days 27 If less than one day hr. min.

9. Birthplace Kidder, (City, town, or county) Kentucky 1 (State or foreign country)

10. Usual occupation Laborer. 7

11. Industry or business

FATHER
12. Name Green Flynn 9
13. Birthplace Unknown (City, town, or county) 1 (State or foreign country)

MOTHER
14. Maiden name Linda Brown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Deceased.
(b) Address

17. (a) Oneida Tenn. (Burial, cremation, or removal) (b) Date thereof 2-2-40 (Month) (Day) (Year)
(c) Place: burial or cremation Oneida, Tenn.

18. (a) Signature of funeral director A. Lohmeyer
(b) Address Funeral Director, Springfield, Mo.

19. (a) 2/2/40 (Date received local registrar) (b) Chas A. George M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 30
year 1940 hour 9 minute 00 P.M.

21. I hereby certify that I attended the deceased from January 3rd, 1940 to January 30, 1940; that I last saw him alive on January 30, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Tuberculosis, Pulmonary, chronic, active, far advanced bi-lateral.	Prior to Adm.
Due to	
Due to	
Other conditions Tuberculosis of the Larynx (Include pregnancy within 3 months of death)	PriorAdm.

Major findings:
Of operations
Of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

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?
(Specify type of place)
While at work? No. (e) Means of injury 1

290 Signature E. W. Green, (M. D. or other)
Address Clinical Director-MCFP. Date signed 1-31-40

(Licensed Embalmer's Statement on Reverse Side)

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 Wayne Hinkle

Licensed Embalmer No. 3446

P. O. Address Springfield, Me

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.