

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 9038  
Registrar's No. 2521

Registration District No. 791

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Anthony's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 33 Days  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days)

8. (a) PRINT FULL NAME ANNA ELYNN

3. (b) If veteran, name war nil 8. (c) Social Security No. nil

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased About 1881  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
About 59 Unknown hr. min.

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

10. Usual occupation Seamstress

11. Industry or business City Hospital

MOTHER FATHER { 12. Name Patrick Flynn  
13. Birthplace Ireland  
(City, town, or county) (State or foreign country)

{ 14. Maiden name Honore McKane  
15. Birthplace Ireland  
(City, town, or county) (State or foreign country)

16. (a) Informant Helen Stair  
(b) Address 1722 Nicholson Place

17. (a) Burial (b) Date thereof Mar. 18, 40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: Burial or cremation Calvary Cemetery-

18. (a) Signature of funeral director John Maxwell De Soto, Mo.  
(b) MAR 16 1940 1826 Allen Ave.

19. (a) MAR 16 1940 (b) J.P. Broadbeck  
(Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis 23  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1732 Iowa Ave.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 15  
year 1940 hour 5 30 minute 9 M.

21. I hereby certify that I attended the deceased from Jan 1  
1940 to March 15, 1940;  
that I last saw her alive on March 15, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

Due to Chronic Myocarditis 6 months

Due to Chronic Interstitial Nephritis 3 months

Other conditions Myocardial Infarction, Pericarditis, Anemia  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature Dr. Robert P. Brink (M. D. or other) \_\_\_\_\_  
Address 1841 So. 132nd St. Date signed 3/15/40

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

**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.....

*Bing C. Hanson*

Licensed Embalmer No.....

*2422*

P. O. Address.....

*1926 Allen*

**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.**