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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 11 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31143

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 3706

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Lakeside Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 Weeks (Specify whether years, months or days)
In this community 50 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City (If outside city or town limits, write "RURAL")
(d) Street No. 6014 Brookside Blvd. (If rural, give location)
(e) If foreign born, how long in U. S. A.? ------- years.

3. (a) PRINT FULL NAME Mrs. Mattie Irene Flinn Westfall
3. (b) If veteran, name war None
3. (c) Social Security No. None
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Mr. George W. Westfall
6. (c) Age of husband or wife if alive -------- years
7. Birth date of deceased May (Month) 9 (Day) 1865 (Year)

8. AGE: Years 75 Months 4 Days 11 If less than one day ..... hr. ..... min.

9. Birthplace Iowa Point (City, town, or county) Kansas (State or foreign country)
10. Usual occupation At Home
11. Industry or business -------
MOTHER FATHER
12. Name Daniel William Flinn
13. Birthplace (City, town, or county) Virginia (State or foreign country)
14. Maiden name Martha A. Fox
15. Birthplace (City, town, or county) Virginia (State or foreign country)
16. (a) Informant D. W. Flinn
(b) Address 6014 Brookside
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 23, 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Forest Hill Cemetery
18. (a) Signature of funeral director O. H. Newcomer's Sons
(b) Address 1401 Brush Creek Blvd.
19. (a) 9-23-40 (Date received local registrar) (b) M. M. Orme (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 20 year 1940 hour 10' minute 5 P M.
21. I hereby certify that I attended the deceased from Aug 31, 1940, to Sept 20, 1940; that I last saw he alive on Sept 20, 1940; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Hemorrhage	
Due to Arterio-Sclerosis	
Due to	
Other conditions (Include pregnancy within 3 months of death) 820	
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? (Specify type of place)
While at work? (e) Means of injury
23. Signature Chas S. Kramer D.O. (M. D. or other)
Address 500 Bryant Bldg Date signed 9/20/40

(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 Kenneth Page Lipe

Licensed Embalmer No. 4125

P. O. Address 1309 Brush Creek

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

If this body is not embalmed, fact should be so stated above.