

No. 2
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17-39
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DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED SEP 12 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

27567

State File No.

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 3225

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: General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 3 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME NOLIE FLYNN

3. (b) If veteran, name war no
3. (c) Social Security No. 496-09-3879

4. Sex Male 5. Color or race Wh
6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Nora Flynn
6. (c) Age of husband or wife if alive 46 years

7. Birth date of deceased Feb. 22, 1891
(Month) (Day) (Year)

8. AGE: Years 50 Months 6 Days 4
If less than one day hr. min.

9. Birthplace Pulaski County, Kentucky
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business W. P. A.

MOTHER FATHER { 12. Name J. D. Flynn
13. Birthplace Kentucky
(City, town, or county) (State or foreign country)
14. Maiden name Nannie Johnson
15. Birthplace Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Nora Flynn

(b) Address 2006 Indiana

17. (a) Removal (b) Date thereof 8-29-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Stanley, Kans.

18. (a) Signature of funeral director Thos. E. Quirk

(b) Address 9 4316 Troost Ave.

19. (a) 9/27/41 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Jackson 040
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 2006 Indiana
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 26 1941
year hour minute M.

21. I hereby certify that I attended the deceased from 9:30 a.
to _____
that I last saw _____ alive on _____ 19____
and that death occurred on the date and hour stated above.
Immediate cause of death _____
Duration _____

Acute acetone poisoning

Due to _____
Other conditions _____
(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) ACCIDENT
(b) Date of occurrence DO NOT KNOW
(c) Where did injury occur? K.C.
(City or town) (County) (State) MO
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work _____ (Specify name of place) (Specify nature of injury)
23. Signature [Signature] (M. D. or other) 3
Address [Signature] Date signed _____

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

SEP 23 1941

MAR 5 1942

DEC 12 1941

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..... *Edward E. Jewell*

Licensed Embalmer No. *3775*

P. O. Address..... *K.P. No*

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, fact should be so stated above.

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

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: General Hospital
(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..... (b) County.....
(c) City or town..... (If outside city or town limits write "RURAL")
(d) Street No..... (If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years.

3. (a) PRINT FULL NAME Nolis Flynn

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

4. Sex Male 5. Color of race Wh 6. (a) Single, widowed, married, divorced Married

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

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

8. AGE: Years 50 Months..... Days..... If less than one day..... hr..... min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....
13. Birthplace..... (City, town, or county) (State or foreign country)
14. Maiden name.....
15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 1-21-1942 (b) M. M. Brown (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 26 year 1941 hour 9:30 minute 00 M.

21. I hereby certify that I attended the deceased from 9:30 that I last saw him alive on..... and that death occurred on the date and hour stated above.

Immediate cause of death.....

Acute Chloroform poisoning

Due to.....

Other conditions..... (Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy No

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

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

(b) Date of occurrence 8-26-41

(c) Where did injury occur? K.C. Jackson Co., Mo (City or town) (County) (State)

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

While at work?..... (Specify kind of place) (Means of injury)

23. Signature Walter H. Baker (M. D. or other) Address K.C. Mo Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

S-27567