

2  
4-41  
7-39  
K22890

Registration District No. **791**  
Primary Registration District No. **1003**

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

**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:  
4154 Connecticut  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether)

In this community Life  
years, months or days

**3. (a) PRINT FULL NAME** Charles V. Flanigan

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Male 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: Oct 30, 1886  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>54</u>	<u>10</u>	<u>13</u>	hr. _____ min.

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

10. Usual occupation Clerk

11. Industry or business \_\_\_\_\_

**MOTHER FATHER**

12. Name James Flanigan

13. Birthplace St. Louis, Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Dalton

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

16. (a) Informant Mrs. Rose Gersbacher,

(b) Address 4154 Connecticut

17. (a) burial (b) Date thereof 9/26/41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olive Cemetery

18. (a) Signature of funeral director Oscar J. Hoffmeister

(b) Address 4016 Chippewa St.

19. (a) SEP 15 1941 (b) J. Budick  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County St Louis

(c) City or town St Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 4154 Connecticut  
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)  
If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month Sept day 13  
year 1941 hour 10 minutes 45 A M.

21. I hereby certify that I attended the deceased from April 12, 39  
Sept 13 1941 to Sept 13 1941  
that I last saw him alive on Sept. 12 1941;  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis Duration about 2 yrs

Due to debility + Emaciation 9 yrs.

Due to Tuberculosis

Other conditions 1  
(Include pregnancy within 3 months of death)

Major findings of operations 1

Of autopsy 1

**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 J. Budick (M. D. or other) \_\_\_\_\_

Address 3146 Morganford Date signed \_\_\_\_\_

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**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 Ernest W. Spillars  
Licensed Embalmer No. 4080

P. O. Address.....

**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.**