

DEC 23 1941 266
Registration District No. _____

Primary Registration District No. 4164

Registrar's No. 61

1. PLACE OF DEATH:

(a) County Dent
(b) City or town Salem
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution X
In this community about 16 years
years, months or days (Specify whether)

3. (a) PRINT FULL NAME Lavina Flynn Gwin

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

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

6. (b) Name of husband or wife W.D. Gwin 6. (c) Age of husband or wife if alive 76 years

7. Birth date of deceased Sept 17 1864
(Month) (Day) (Year)

8. AGE: Years 77 Months 1 Days 7 If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business X

12. Name Peter Flynn
13. Birthplace Utica NY
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Goble
15. Birthplace Dowagiac Mich
(City, town, or county) (State or foreign country)

16. (a) Informant Willard P. Gwin

(b) Address Salem Mo

17. (a) Removal (b) Date thereof Feb 25 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Koota, Ia

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

(b) Address Salem Mo

19. (a) 10-25-41 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dent
(c) City or town Salem Mo
(If outside city or town limits, write "RURAL")
(d) Street No. X
(If rural, give location)
(e) If foreign born, how long in U. S. A.? X years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 24
year 1941 hour 5 minute 30 A. M.

21. I hereby certify that I attended the deceased from 10-24-41, 19____, to 10-24-41, 19____; that I last saw IC alive on 10-24-41, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death central hemorrhage

Due to hypertension - arteriosclerosis

Due to _____

Other conditions (include pregnancy within 3 months of death) 73a

Major findings: Of operations _____

Of autopsy _____

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 2

23. Signature Jas D. [Signature] (M. D. or other) DO.
Address Salem Mo Date signed 10-25-41

Duration 7 days
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 5,

District File Number 11412083

Date Filed: _____

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 Carl H. Jensen

Licensed Embalmer No. 2370

P. O. Address Salisbury, Me

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.