DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 14 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 7170

Registration District No. 502 | Primary Registration District No. 4305 | Registrar's No. 8

1. PLACE OF DEATH:

(a) County Linn

(b) City or town Marceline, Mo (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Putman Memorial Hospital ( ) (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 12 days (Specify whether

In this community 3½ months years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Linn 5 8

(c) City or town Marceline, Mo 2 (If outside city or town limits, write "RURAL")

(d) Street No. 200 W. Lake 1 (If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME WILLDORA BURKE FLYNN

3. (b) If veteran, name war no

3. (c) Social Security No. 500-07-8735

4. Sex female ✓

5. Color or race white

6. (a) Single, widowed, married, divorced married ✓

6. (b) Name of husband or wife Charles Micheal Flynn

6. (c) Age of husband or wife if alive 25 years

7. Birth date of deceased Sept. (Month) 1 (Day) 1919 (Year)

8. AGE: Years 22 | Months 5 | Days 16 | If less than one day ___ hr. ___ min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Edward Tooey
13. Birthplace Brookfield, (City, town, or county) O Missouri (State or foreign country)

MOTHER
14. Maiden name Maude Burke
15. Birthplace Holleyville (City, town, or county) Iowa (State or foreign country)

16. (a) Informant's own signature Charles M Flynn

(b) Address Marceline, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-20-1942 (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Killiard

18. (a) Signature of funeral director James M Laughlin

(b) Address Marceline, Missouri

19. (a) 2-19-42 (Date received local registrar) (b) Olive L Barrett (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 17 year 1942 hour 7 minute 45 M.

21. I hereby certify that I attended the deceased from Jan 12, 1942, to Feb 17, 1942; that I last saw her alive on Feb 17, 1942; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hemorrhage from colon	3 hrs
Due to: acute ulcerative colitis	6 months
Due to:	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations 1200
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 G B Putman (M. D. or other) MD

Address Marceline Mo Date signed 2/19

(Licensed Embalmer's Statement on Reverse Side)

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Rev. 5-17-39 1 X19511

MAR 1 2 1942

AUG 2 1940

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 Blanche W. Laughlin

Licensed Embalmer No. 1909

P. O. Address Marceline, MO.

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.