

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

FILED AUG 11 1943 149

Registration District No. 149

Primary Registration District No. 1002

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:  
4111 Terrace /  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 49 years (Specify whether)  
years, months or days

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. 4111 Terrace  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MRS. NELLIE FLYNN

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife James Flynn 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Feb 2 1875  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
68 5 28 hr. min.

9. Birthplace Ireland 4  
(City, town, or county) (State or foreign country)

10. Usual occupation Houswife

11. Industry or business

12. Name Daniel Shine

13. Birthplace Ireland 4  
(City, town, or county) (State or foreign country)

14. Maiden name Mary Ahearne

15. Birthplace Ireland 4  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Patrick J Ryan

(b) Address 4111 Terrace

17. (a) Burial (b) Date thereof 8/2/43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Marys' Cemetery

18. (a) Signature of funeral director Frank & Robin Co

(b) Address 20 West Linwood

19. (a) 7-31-43 (b) J. E. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 30th day July  
year 1943 hour 4:30 minute P M.

21. I hereby certify that I attended the deceased from July 29, 1943  
to July 30, 1943  
that I last saw her alive on July 30, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic heart disease

Due to 48 hr

Other conditions Cerebral embolism of fungus of uterus  
(Include pregnancy within 3 months of death)

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 \_\_\_\_\_

23. Signature Charles Owens (M. D. or other)  
Address 906 Grand NCA Date signed 7-31-43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

**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.....

*Charles M. Quinn*

Licensed Embalmer No.....

*3774*

P. O. Address.....

*K. C. 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, fact should be so stated above.**