

FILED AUG 23 1944
Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

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: St. Joseph Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Week
(Specify whether)

In this community 30 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 118

(c) City or town Kansas City
(If outside city or town limits, write "RURAL") 3

(d) Street No. 4415 Belleview
(If rural, give location) 8

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country _____

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

(b) If veteran, name war No

(c) Social Security No None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6th day Aug
year 1944 hour 10:30 minute P M.

21. I hereby certify that I attended the deceased from July 27
1944, 19 , to Aug 6, 1944
that I last saw her alive on Aug 6 1944, 19 ;
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife William S Flynn

6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased July 14
(Month) (Day) (Year) 1884

Immediate cause of death _____
Bronchical Pneumonia 4 Days

Due to Empyema of Gall Bladder 8 Days

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

60 0 22 hr. min.

Due to _____

Other conditions (Include pregnancy within 3 months of death) 127a

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

10. Usual occupation Housewife

Major findings: see above

Of operations _____

Of autopsy No

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

MOTHER FATHER

11. Industry or business _____

12. Name Jerimiah Vance

13. Birthplace New York
(City, town, or county) (State or foreign country)

14. Maiden name Ellen Labore

15. Birthplace No record
(City, town, or county) (State or foreign country)

16. (a) Informant William S Flynn

(b) Address 4415 Belleview

17. (a) Burial (b) Date thereof Aug 9 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Mark E. Tobin

(b) Address 20 West Linwood

19. (a) 8-8-44 (b) N. E. Brown
(Date received local registrar) (Registrar's signature)

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? _____ (c) Means of injury _____

23. Signature John T. Shriver (M. D. or other) M. D.

Address 1102 Bryant Bldy Date signed 8/8/44

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

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. Furrk

Licensed Embalmer No. 3774

P. O. Address Kansas City, 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.