

FILED JAN 16 1945
Registration District No. 318

Primary Registration District No. _____

State File No. _____

Registrar's No. 111

2011
207

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

1. PLACE OF DEATH:

(a) County St. Louis, Missouri.
 (b) City or town St. Louis, Missouri.
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Louis City Hospital-Max C. Starkloff
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 13 days Memorial
(Specify whether)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Peter Flanagan

3. (b) If veteran, name war None 3. (c) Social Security No. 487-20-504

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 Aug 22nd. 1898
(Month) (Day) (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-----------|----------|-----------|----------------------|
| | <u>46</u> | <u>4</u> | <u>11</u> | _____ hr. _____ min. |

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

10. Usual occupation Cook

11. Industry or business Koch Hospital

MOTHER FATHER { 12. Name John Flanagan 4
 { 13. Birthplace Ireland 4
(City, town, or county) (State or foreign country)
 { 14. Maiden name Mary Horan 4
 { 15. Birthplace Ireland 4
(City, town, or county) (State or foreign country)

16. (a) Informant Edward Flanagan
 (b) Address 4519 Genevieve Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/6/45
(Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemt

18. (a) Signature of funeral director Harrigan & Sheahan Und Co
 (b) Address 4415 Washington Blvd

19. (a) JAN 5 1945 (Date received local registrar) J. Medicine (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County _____
 (c) City or town St. Louis
(If outside city or town limits, write "RURAL")
 (d) Street No. 3023 Elliot Ave
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 3rd
 year 1945 hour 7:30 minute P. M.

21. I hereby certify that I attended the deceased from 12/18/44
 _____, 19____, to _____, 19____;
 that I last saw him alive on 1/3/45, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Respiratory failure + pneumonia - unspecified Duration _____

Due to unknown cause

Due to _____

Other conditions Laryngeal & Pharyngeal paralysis + atrophy unknown
(include pregnancy within 3 months of death)

Major findings: Of operations _____
109.1
 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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Russell Sigel, Jr. (M, D, or other) _____
1515 Lafayette Date signed 1/4/45
 Address _____

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..... *Robert G. Hoffe*

Licensed Embalmer No. *297*.....

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.