

S. No. 2
OM-8-43
ev. 5-17-39
I X3752

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1102

State File No.

FILED JAN 26 1945

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 110

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:
6017 Forest Ave
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 20 Years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Mrs Gladys Flynn

3. (b) If veteran, name war None

3. (c) Social Security No. None

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

6. (b) Name of husband or wife James V. Flynn 6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased July 17 1895
(Month) (Day) (Year)

8. AGE: Years 49 Months 5 Days 21 If less than one day hr. min.

9. Birthplace Garrison / Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business At Home

12. Name August Raban

13. Birthplace Unknown / France
(City, town, or county) (State or foreign country)

14. Maiden name Josephine Billewood

15. Birthplace Omega / Kansas
(City, town, or county) (State or foreign country)

16. (a) Informant James Flynn

(b) Address 6017 Forest Ave

17. (a) Burial (b) Date thereof 1-11-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Melody-McGilley

(b) Address Kansas City Missouri

19. (a) 1-9-45 (b) N. E. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City Missouri 47
(If outside city or town limits, write "RURAL.")

(d) Street No. 6017 Forest Ave 3
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 8
year 1945 hour 1 minute 20 P. M.

21. I hereby certify that I attended the deceased from July 21, 1943 to Jan 8, 1945
that I last saw her alive on Jan 6, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinomatous - 2 yrs

Due to Carcinoma of Left Breast 5 yrs

Due to 50

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations Carcinoma of Left Breast Underline the cause to which death should be charged statistically.

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 work) (e) Means of injury 0

23. Signature Republican (M. D. or other) 1/9/45
Address 1103 Grand Date signed

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

MOTHER FATHER

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.....

- - Licensed Embalmer No.....

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.