

STANDARD CERTIFICATE OF DEATH

State File No.

35264  
9363

FILED NOV 19 1945  
318

Primary Registration District No. 1003

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Louis.

(b) City or town St. Louis.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: City Infirmary  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 yr. 8 mo. 2 days  
(Specify whether years, months or days)

In this community 5 years.  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME MOLLIE FLYNN.

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

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

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

7. Birth date of deceased 12 1853  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	91	10	21	hr. min.

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

10. Usual occupation Nil

11. Industry or business \_\_\_\_\_

12: Name Unknown

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

14. Maiden name "

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

16. (a) Informant Wm. Windsheimer.  
(b) Address 5800 Arsenal, St.

17. (a) Burial (b) Date thereof Nov 6, 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park Cemetery

18. (a) Signature of funeral director Moel Vasser  
(b) Address 2812 Cass Ave.

19. (a) NOV 5 1945 (b) J. F. Bredeek  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis.

(c) City or town St. Louis.  
(If outside city or town limits, write "RURAL")

(d) Street No. 5800 Arsenal St.  
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 13rd;  
year 1945 hour 2:30 A.M. minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from July  
the 2nd; 19 45 to November 3, 19 45;  
that I last saw her alive on November 3, 19 45;  
and that death occurred on the date and hour stated above.

Immediate cause of death Generalized Arteriosclerosis Duration Sev. yrs

Due to Senility

Due to 97

Other conditions 97  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
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) (c) Means of injury \_\_\_\_\_

23. Signature Palmer Prinson Bowdler (M. D. or other) \_\_\_\_\_  
Address 5800 Arsenal St Date signed 11-4-45

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.....

*My Self*  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed *R.C. Hows*  
.....  
Licensed Embalmer No. *2286*

P. O. Address *2812 Thomas St*

**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.**