

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12233

State File No.

Registrar's No. 395

FILED APR 17 1946

Registration District No. 42

Primary Registration District No. 1000

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3233 Lafayette St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution None
(Specify whether)
In this community 74 Years
years, months or days)

3. (a) PRINT FULL NAME Frances Flynn Elders

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 Widowed
6. (b) Name of husband or wife Dr. H. Will Elders 6. (c) Age of husband or wife if alive * years
7. Birth date of deceased May 28 1871
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
74 10 5 hr. min.

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

10. Usual occupation Housewife

11. Industry or business None

MOTHER FATHER { 12. Name John J. Flynn
13. Birthplace Unknown Ireland 4
(City, town, or county) (State or foreign country)
14. Maiden name Harriet Vivion
15. Birthplace Unknown England 4
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Yvonne Elders
(b) Address 3233 Lafayette St.

17. (a) Removal (b) Date thereof Apr. 5, 1946
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Richwoods, Missouri

18. (a) Signature of funeral director Herman W. L. L. L. L. L.
(b) Address 1802 Union St. St. Joseph, Mo.

19. (a) April 6, 1946 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan //
(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 3233 Lafayette 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 April day 3
year 1946 hour 3 minute 10 A.M.

21. I hereby certify that I attended the deceased from Oct 11 1945 to Apr. 2 1946;
that I last saw her alive on Apr 2 1946;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration Hours?

Due to arteries for gen

Due to

Other conditions Mitral Stenosis
(Include pregnancy within 3 months of death)

Major findings:
Of operations [Signature]
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 [Signature]

23. Signature [Signature] (M.D. or other)
Address 620 [Signature] Date signed 4/3/46

11142
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

APR 18 1940

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.