

FILED JUN 14 1947

Registration District No. **322**

Primary Registration District No. **44923071**

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

1. PLACE OF DEATH:

(a) County **Saline Co**

(b) City or town **Slater Mo**  
(If outside city or town limits, write "RURAL" and name of township)

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

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

In this community **25 years**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Saline 92**

(c) City or town **Slater**  
(If outside city or town limits, write "RURAL")

(d) Street No. **415-North Main Street**  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Marshall Allen Flynn**

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. **311-10-7432**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **2** year **1947** hour **4:45** minute \_\_\_\_\_ P.M.

4. Sex **Male** 5. Color or race **white**

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

6. (b) Name of husband or wife **Bessie** 6. (c) Age of husband or wife if alive **66** years

7. Birth date of deceased **June 28, 1888**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **June 2, 1947** to **June 2, 1947** that I last saw h. p. m. alive on **June 2, 1947** and that death occurred on the date and hour stated above.

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

**58** **11** **4** hr. min.

Immediate cause of death **Coronary Occlusion** **20 M.**

Duration \_\_\_\_\_

9. Birthplace **Charleston Arkansas**  
(City, town, or county) (State or foreign country)

Due to \_\_\_\_\_

Due to \_\_\_\_\_

10. Usual occupation **F.H. Fireman**

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

11. Industry or business **F.R.**

Major findings: Of operations **94X**

12. Name **James B. Flynn**

Of autopsy \_\_\_\_\_

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

14. Maiden name **Lora Blitt**

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

16. (a) Informant **Mrs Bessie Flynn**

(b) Address **816 W. Monroe Mexico Mo**

17. (a) **Removal** (b) Date thereof **June 8-1947**  
(Month) (Day) (Year)

(c) Place: burial or cremation **Gary, Indiana**

18. (a) Signature of funeral director **Jones and Salzer**

(b) Address **Slater Mo**

19. (a) **June 5, 1947** (b) **Mrs. Earl C. Metz**  
(Date received local registrar) (Registrar's signature)

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? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_

While at work? (e) Means of injury **L**

23. Signature **E. J. Howard** (M. D. or other) \_\_\_\_\_  
Address **Slater Mo** Date signed **6/4/47**

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 6-14-47

1947

AUG 1 1947

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 \_\_\_\_\_

*James E. Jones*  
3143  
State

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.