

**FILED OCT 11 '947**

Registration District No. **749**

Primary Registration District No. **1002**

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

**1. PLACE OF DEATH:**  
(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Joseph Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution since 9-23-47  
In this community 3 1/2 years (Specify whether years, months or days)

**3. (a) PRINT FULL NAME** Mrs. Anna Flanagan  
**3. (b) If veteran, name war** no. **3. (c) Social Security No.** no.

**4. Sex** female **5. Color or race** white  
**6. (a) Single, widowed, married, divorced** widowed  
**6. (b) Name of husband or wife** B. H. Flanagan  
**6. (c) Age of husband or wife if alive** dec. years  
**7. Birth date of deceased** October 10 1876  
(Month) (Day) (Year)

**8. AGE:** Years 70 Months 11 Days 20 If less than one day hr. min.

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

**10. Usual occupation** at home

**11. Industry or business** X

MOTHER FATHER

**12. Name** Martin Summey  
**13. Birthplace** unknown (City, town, or county) (State or foreign country)  
**14. Maiden name** Hattie Litchfield  
**15. Birthplace** Ohio (City, town, or county) (State or foreign country)

**16. (a) Informant** Mrs. C. Henry

**(b) Address** 1020 Romany Road, Kansas City, Mo.

**17. (a) Removal** (Burial, cremation, or removal) Removal **(b) Date thereof** 9-30-47 (Month) (Day) (Year)

**(c) Place: burial or cremation** Melcher, Iowa

**18. (a) Signature of funeral director** Stine & McClure

**(b) Address** 3235 Gillham Plaza, K. C., Mo.

**19. (a) 9-30-47** (Date received local registrar) **(b) Geraldine Holmes** (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State Missouri (b) County Jackson  
(c) City or town Kansas City (If outside city or town limits, write "RURAL")  
(d) Street No. 1020 Romany Road (If rural, give location)  
(e) Citizen of foreign country? no. (Yes or No)  
If yes, name country X

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month Sept day 30 year 1947 hour 4:30 minute AM  
**21. I hereby certify that I attended the deceased from** 9/23/47 to 9/29/47 that I last saw her alive on 9/29/47 and that death occurred on the date and hour stated above.

Immediate cause of death Paralytic Dysentery  
Coronary Occlusion

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

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

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

**Major findings:** 94a  
**Of operations** \_\_\_\_\_  
**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?** \_\_\_\_\_

**23. Signature** William McKee (Specify type of physician) (M. D. or other) MD  
**Address** Professional Bldg **Date signed** 9/30/47

**Physician**  
4/23/47  
W.H.  
**Underline the cause to which death should be charged statistically.**

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**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 J. Blair Sheppard  
Licensed Embalmer No. 14978  
P. O. Address K. C. Mo

**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.**