No. 2
-1/47
-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED MAR 4 1948

Registration District No. 318

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 6350

Registrar's No. 1690

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution: DePaul Hospital 0
(If not in hospital or institution, write street number or location)

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

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: ST. LOUIS 96

(c) City or town: CLAYTON 2
(If outside city or town limits, write "RURAL")

(d) Street No.: 8025 Venetian Dr. 3
(If rural, give location)

(e) Citizen of foreign country? N.R. (Yes or No) 1

If yes, name country

3. (a) PRINT FULL NAME: Jane Flynn

3. (b) If veteran, name war: No

3. (c) Social Security No.: None

4. Sex: Female 1

5. Color or race: White

6. (a) Single, widowed, married, divorced: Widow 2

6. (b) Name of husband or wife: Thomas Flynn

6. (c) Age of husband or wife if alive: years

7. Birth date of deceased: March (Month) 21 (Day) 1876 (Year)

8. AGE:

Years	Months	Days	If less than one day
71	10	20	hr. min.

9. Birthplace: Sheffield (City, town, or county) Illinois (State or foreign country) 1

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: William Fohey
13. Birthplace: Ireland (City, town, or country) (State or foreign country) 4

MOTHER
14. Maiden name: Elizabeth O'Connell
15. Birthplace: New York (City, town, or country) (State or foreign country) 1

16. (a) Informant: E. Paul Smith
(b) Address: 8025 Venetian Dr.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 2-14-48 (Month) (Day) (Year)
(c) Place: burial or cremation: Hannibal, Mo.

18. (a) Signature of funeral director: Albert H. Hoppe
(b) Address: 4700 Washington Blvd

19. (a) FEB 18 1948 (Date received local registrar) (b) J. F. Budeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 11 year 1948 hour 5 minute 45 P.M.

21. I hereby certify that I attended the deceased from Feb 7 1948 to Feb 11 1948 that I last saw her alive on Feb 11 1948 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Hemiplegia	4 days
Due to: Hypertension	2 yrs
Due to:	
Other conditions (Include pregnancy within 3 months of death): 82	

Major findings:
Of operations:
Of autopsy:

PHYSICIAN — Underline the cause of 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? (Specify type of place) Means of injury: 0

23. Signature: [illegible] (M. D. or other)
Address: 4452 Maryland Date signed: 2-12-48

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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.....Ernest W. Gillers

Licensed Embalmer No.....4080

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.