

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED JUN 26 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 19467
Registrar's No. 2507

Registration District No. 149

Primary Registration District No. 1602

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: General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days
(Specify whether
In this community Unknown
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. Helping Hand Institute
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Frank Flynn

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased Dec. 9 1885
(Month) (Day) (Year)

8. AGE: Years 62 Months 5 Days 28 If less than one day hr. _____ min. _____

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

10. Usual occupation Pensioner

11. Industry or business _____

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Record Clerk

(b) Address K.C. General Hosp. #1

17. (a) Anatomical (b) Date thereof 6-12-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Western Dental College

18. (a) Signature of funeral director Weilert Funeral Home

(b) Address 2332 Monitor Place, K. C. Mo.

19. (a) 6-15-48 (b) Steraldine Holmer
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 7 year 1948 hour 4 minute 35 P.M.

21. I hereby certify that I attended the deceased from June 3 48, 1948, to June 7 48, 1948; that I last saw him alive on June 7, 1948; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebrovascular accident Duration _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 830

Major findings: Of operations _____

Of autopsy NONE

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 _____

23. Signature Wm W. Ward (M. D. or other) MD
Address Med. Dir. Gen'l Hosp. Date signed 6-8-48

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

Blaine

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 *Blaine E. Weiler*

Licensed Embalmer No. *4075*

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.