

MISSOURI DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **25000**

FILED JUL 31 1948

Registration District No. **217**

Primary Registration District No. **6076**

Registrar's No. **81759**

1. PLACE OF DEATH:

(a) County **Saint Louis county**
(b) City or town **Rural**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Robert Koch Hospital (-)**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **since 2-19-48**
(Specify whether years, months or days) **3 years**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Saint Louis**
(c) City or town **Delmar**
(If outside city or town limits, write "RURAL")
(d) Street No. **9930 Delmar**
(If rural, give location)
(e) Citizen of foreign country? _____ (Year No)
If yes, name country _____

3. (a) PRINT FULL NAME **FLANAGAN, MAXINE MARIE**

3. (b) If veteran, name war _____
3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **7** day **17** year **1948** hour **2** minute **15 P.M.**

21. I hereby certify that I attended the deceased from **2-19-1948** to **7-17-1948**
that I last saw him alive on **7-17-1948**
and that death occurred on the date and hour stated above.

Immediate cause of death **chronic Pulm. Tuberculosis**
Duration **3 years**

4. Sex **Female** 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Arceious Flanagan** 6. (c) Age of husband or wife if alive **26** years
7. Birth date of deceased **7-27-1927**
(Month) (Day) (Year)

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

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

10. Usual occupation **mil.**

11. Industry or business _____

12. Name **Bush Ward**

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

14. Maiden name **Marie Muldrow**

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

16. (a) Informant **Koch Hosp Records**

(b) Address **Koch Mo.**

17. (a) **Burial** (b) Date thereof **7-22-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Washington Park Cem,**

Ellis Funeral Home

18. (a) Signature of funeral director **2820 Stoddard St**

(b) Address _____

19. (a) **7-21-48** (b) **Earl G. Stoddard**
(Date received local registrar) (Registrar's signature)

Due to _____

Due to **138**

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

Major findings: 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? _____

(Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature **Bernard Friedman** (M. D. or other) **M.D.**

Address **Koch Hosp, Koch, Mo.** Date signed **7-17-48**

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

MOTHER FATHER

JUL 21 1948

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: *William E. Culkin*

Licensed Embalmer No. *4198*

P. O. Address: *St. Louis 13 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.