

D. 300  
10-47  
17-39  
I 3906

FILED DEC 8 1948

Registration District No. **318**

Primary Registration District No. **1003**

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

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:  
St. Louis Children's Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community \_\_\_\_\_ years, months or days (Specify whether 1)

2. USUAL RESIDENCE OF DECEASED:

(e) State Mo. (b) County 13

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 5050 Winona Ave.  
(If rural, give location) -1

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME JOSEPH EDWARD FLYNN JR.

3. (b) If veteran, name war None

3. (c) Social Security No. \_\_\_\_\_

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 Sep't. 16 1948  
(Month) (Day) (Year)

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

0	2	10	hr. _____ min.
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9. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business \_\_\_\_\_

12. Name Joseph Edward Flynn Sr.

13. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Rita Regan

15. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Joseph Edward Flynn Sr.  
(b) Address 5050 Winona Ave.

17. (a) Burial (b) Date thereof 11-29-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation RESURRECTION CEM.

18. (a) Signature of funeral director Kriegshauser Und. Co.  
(b) Address 4228 So. Kingshighway Bl.

19. (a) NOV 27 1948 (b) J. B. Breater  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 26  
year 1948 hour 6:30 minute A. M.

21. I hereby certify that I attended the deceased from 10-9-48  
to 11-26-48, 1948  
that I last saw him alive on 11-25-48, 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia Duration 3 weeks

Due to Congenital Cystic Fibrosis of Pancreas

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

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

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy Not repeated yet.

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 2

23. Signature [Signature] (M. D. or other) MD.  
Address 4530 N. Lincoln Ave. Date signed 11-26-48

10290

453 No. 100

**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 *Edwin M. Bernath*

Licensed Embalmer No. *3024*

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.**