

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED SEP 22 1949

State File No. 32530

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 2185

1. PLACE OF DEATH a. COUNTY <u>St. Louis County</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Koch, Mo.</u>		c. LENGTH OF STAY (In this place) <u>197 days</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		9
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Robert Koch Hospital</u>			d. STREET ADDRESS (If rural, give location) <u>1617 South 2nd Street</u>		

3. NAME OF DECEASED (Type or Print) a. (First) <u>Ray</u> b. (Middle) <u>-</u> c. (Last) <u>Flannigan</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>9 11 1949</u>		
--	--	--	---	--	--

5. SEX <u>M-U</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>1/8/99</u>	9. AGE (In years last birthday) <u>50</u>	IF UNDER 1 YEAR Months _____	IF UNDER 1 YEAR Days _____	IF UNDER 1 HR. Hours _____	IF UNDER 1 HR. Min. _____
-------------------	----------------------------	---	--------------------------------	---	------------------------------	----------------------------	----------------------------	---------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nil</u>		10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>	11. BIRTHPLACE (State or foreign country) <u>Franklin Co., Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
--	--	---	---	--	--

13a. FATHER'S NAME <u>Monroe Flannigan</u>	13b. MOTHER'S MAIDEN NAME <u>Anna Mabry</u>	14. NAME OF HUSBAND OR WIFE <u>Katherine Thomas (Deceased)</u>
--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes, give war or dates of service) <u>unk.</u>	16. SOCIAL SECURITY NO. <u>350-20-3152</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Rob't Koch Hosp. Records, Koch, Mo.</u>
--	--	--

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary Tuberculosis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>11 yrs.</u>
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Adenocarcinoma of Stomach</u>		<u>9 mos.</u>

19a. DATE OF OPERATION <u>12/17/48</u>	19b. MAJOR FINDINGS OF OPERATION <u>Adenocarcinoma of Stomach (Subtotal Resection)</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
--	--	--	--

21a. ACCIDENT SUICIDE HOMICIDE <input checked="" type="checkbox"/> (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input checked="" type="checkbox"/>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <input checked="" type="checkbox"/>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <input checked="" type="checkbox"/>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <input checked="" type="checkbox"/>

22. I hereby certify that I attended the deceased from 7/15, 1949, to 9/11, 1949, that I last saw the deceased alive on 9/10, 1949, and that death occurred at 8:35 A.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>John W. Beckham, M.D.</u>	23b. ADDRESS <u>Rob't Koch Hosp., Koch, Mo.</u>	23c. DATE SIGNED <u>9/11/49</u>
---	---	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>9-11-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Unknown</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>
--	--------------------------	---	---

DATE REC'D BY LOCAL REG. <u>9-13-49</u>	REGISTRAR'S SIGNATURE <u>Robert Koch</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Rowland Mortuary Service Inc. 4104 Manchester Ave. St. Louis 10, Mo.</u>
---	--	--

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

23-F

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed Ronald O. Yelms

Signed _____
Student Embalmer

Licensed Embalmer No. 3917

P. O. Address St Louis 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.