

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

33506

State File No. 4368

FILED NOV 4 1950

BIRTH NO. REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 4368

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Kansas City</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Kansas City</b>	
c. LENGTH OF STAY (in this place) <b>39 yrs.</b>		d. STREET ADDRESS (If rural, give location) <b>3011 Charlotte</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Mary's Hospital</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>William</b> b. (Middle) <b>E.</b> c. (Last) <b>FLYNN</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Oct. 13, 1950</b>	
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5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>3-18-81</b>	9. AGE (In years last birthday) <b>69</b>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HR. Hours	IF UNDER 1 HR. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Mail Carrier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>K. C. Post Office</b>		11. BIRTHPLACE (State or foreign country) <b>Chicago, Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
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13a. FATHER'S NAME <b>John Flynn</b>		13b. MOTHER'S MAIDEN NAME <b>Margaret Leahy</b>		14. NAME OF HUSBAND OR WIFE <b>Anna A. Flynn</b>			
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Anna A. Flynn, 3011 Charlotte, KC, Mo.</b>			
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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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Hemorrhage</b>						INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Hypertension</b>						<b>5+ yr</b>	
		DUE TO (c) <b>Uremia</b>						<b>33 1/2</b>	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						<b>7 days</b>	

19a. DATE OF OPERATION <b>Oct 3 '50</b>		19b. MAJOR FINDINGS OF OPERATION <b>Prostatic Hypertrophy</b>						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)			21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from **Sept 22, 1950**, to **Oct 13, 1950**, that I last saw the deceased alive on **Oct 13, 1950**, and that death occurred at **5:45 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Wm. A. Staggs</b>		23b. ADDRESS <b>822 Argyle K.C. Mo.</b>		23c. DATE SIGNED <b>10-16-50</b>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>10-16-50</b>		24c. NAME OF CEMETERY OR CREMATORY, AND LOCATION (City, town, or county) (State) <b>Calvary Kansas City, Missouri</b>	
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DATE REC'D BY LOCAL REG. <b>10-16-50</b>		REGISTRAR'S SIGNATURE <b>Geraldine Holmes</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Melody-McGilley-Eylar, Kansas City, Mo.</b>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. Alan A. Hester  
822 Orange  
after 11:30 AM  
10/15/75

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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed \_\_\_\_\_

Signed .....  
Student Embalmer

Licensed Embalmer No. \_\_\_\_\_

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.