

health, Welfare public service  
 000-56  
 diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.  
 registered. All  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

FILED DEC 27 1956

43020

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's **11202**

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY				a. STATE <b>Missouri</b>		b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only)		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
OR TOWN <b>ST. LOUIS, MISSOURI</b>				STREET ADDRESS <b>3001 Park avenue</b> (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSPITAL #1.</b>				Length of stay in lb <b>2/898</b>			
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH		Month Day Year	
First <b>ROBERT</b> Middle <b>FLANAGAN</b> Last <b>FLANAGAN</b>				Month <b>DECEMBER</b> Day <b>6</b> Year <b>1956</b>			
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<b>male</b>	<b>white</b>	WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	<b>4-8-1910</b>	<b>46</b>	Months Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY?	
<b>tavern operator</b>		<b>Tavern</b>		<b>Logan, Ill.</b>		<b>USA</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<b>George Flanagan</b>				<b>unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
<b>no</b>		<b>unknown</b>		<b>Ewell Flanagan, Northville, Mich.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Coma</b>							
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Laennec's Cirrhosis of liver</b>							
DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
			<b>581.1</b>				
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.							
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE,	
21. I attended the deceased from <b>12/4/56</b> to <b>12/6/56</b> and last saw her alive on <b>12/6/56</b> Death occurred at <b>7:40 P. M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title)				22b. ADDRESS		22c. DATE SIGNED	
<b>R. P. Trayer M. D.</b>				<b>1515 PALAYETTE AVE.</b>		<b>12/7/56.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<b>removal</b>		<b>12-7-56</b>		<b>West Frankfort, Ill</b>			
24. FUNERAL DIRECTOR ADDRESS			25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE		
<b>Walker, West Frankfort, Ill.</b>			<b>DEC 7 1956</b>		<b>Paul Smith M.D.</b>		

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..

Student.....  
Signature of Student Embalmer

Signed *Horner M. Fritz*.....  
Licensed Embalmer No. ....

P. O. Address *St. Louis*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.