

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

**1694**

STATE FILE NUMBER

**FILED MAR 4 1957** Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 602

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, give TOWNSHIP only) OR TOWN <b>Kansas City, Mo.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Raytown,</b>		5000 0	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Mary's Hosp.</b>			Length of stay in lb <b>3 days</b>	d. STREET ADDRESS <b>6609 Ralston</b> (If outside, give location)			Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>W</b> Last <b>FLYNN</b>				4. DATE OF DEATH Month <b>2</b> Day <b>8</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 29, 1890</b>		9. AGE (In years last birthday) <b>66</b>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Telephager</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Bonds &amp; Securities</b>	11. BIRTHPLACE (City and state or country) <b>Kansas City, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Wm. W. Flynn</b>				14. MOTHER'S MAIDEN NAME <b>Harriett</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>406-05-1449</b>	17. INFORMANT Address <b>Mrs. Mattie Flynn 6609 Ralston</b>			
18. CAUSE OF DEATH [Enter only one cause per line in (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Jan 1957</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Senescent arteriosclerosis</b>						<b>10 yrs.</b>	
DUE TO (c) _____						<b>4200</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diphtheria Malleus 10 yrs duration</b>						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>1</b>					
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____							
20d. INJURY OCCURRED WHILE AT WORK <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>1/2/57</b> to <b>2/8/57</b> and last saw her/him alive on <b>2/8/57</b> . Death occurred at <b>5105 A.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>C. G. Leitch</b> (Degree or title) _____				22b. ADDRESS <b>6010 Perry Bellway, KCMO</b>		22c. DATE SIGNED <b>2/8/57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>2-11-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Mora Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Joseph, Missouri</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Mellody-McGilley-Eylar Funeral Home</b>				25. DATE RECD. BY LOCAL REG. <b>2-8-57</b>		26. REGISTRAR'S SIGNATURE <b>Reva Marshall</b>	

1800 E. Linwood

(Licensed Embalmer's Statement on Reverse Side)

health, welfare, public service  
 300 -56  
 diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.  
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

*Dr. C. J. Leitch  
Prof. Body  
Uc 21109*

*12 - 5 PM*

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em-  
by me, or by ....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....  
*[Handwritten Signature]*

Licensed Embalmer No.....  
*2990*

P. O. Address.....  
*[Handwritten Address]*

**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.**