

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8664

STATE FILE NUMBER

996

FILED MAR 20 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 996

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3930 Harrison			Length of stay in 13 Yrs.		d. STREET ADDRESS 3930 Harrison		(If outside, give location) Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM PETER FLYNN				First	Middle	Last	4. DATE OF DEATH Month 3 Day 3 Year 57	
5. SEX Male	6. COLOR OR RACE Wh.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-20-1878		9. AGE (In years last birthday) 78		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner & manager			10b. KIND OF BUSINESS OR INDUSTRY Confectionary		11. BIRTHPLACE (City and state or country) Shackleford Mo.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Flynn				14. MOTHER'S MAIDEN NAME Delia Keating				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mae R. Flynn			Address 3930 Harrison KCMO.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease - Failure							INTERVAL BETWEEN ONSET AND DEATH 3 yrs.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) Myocardial Insufficiency				INTERVAL BETWEEN ONSET AND DEATH 3 yrs.	
			DUE TO (c) Arteriosclerosis, Generalized				INTERVAL BETWEEN ONSET AND DEATH 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hepatic Cirrhosis Mod. severe							4200	
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.) None					
20c. TIME OF INJURY Hour Month, Day, Year. None			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.) None			20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from 1951 to 3-3-57 and last saw him alive on 3-2-57 Death occurred at 3:45 P. m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE Harold A. Budke				22b. ADDRESS 1019 ARBYNE Bldg		22c. DATE SIGNED 3/4/57		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-8-57	23c. NAME OF CEMETERY OR CREMATORY Slater Cemetery		23d. LOCATION (City, town, or county) Slater		STATE MO.	
24. FUNERAL DIRECTOR Melody-McGilley-Eylar			ADDRESS KCMO.		25. DATE RECD. BY LOCAL REG. 3-4-57		26. REGISTRAR'S SIGNATURE Beva Minshall	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
Harold A. Budke

000
-56
Director, County, etc. must be usually attached. Coroner cannot certify to a death due to natural causes.

Dr H.A. Budke
10 19 Argyle

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 *J. W. Wair*.....

Licensed Embalmer No. *46*

P. O. Address *K.C.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.