

FILED JUL 5 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20114

STATE FILE NUMBER

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 705

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		c. CITY OR TOWN St. Joseph 0117 0	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION D.O.A.		d. STREET ADDRESS (If outside, give location) 1224 N. 2nd	
3. NAME OF DECEASED (Type or print) First Middle Last Robert E. Flynt		4. DATE OF DEATH Month Day Year June 26, 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 3, 1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Brewery	11. BIRTHPLACE (City and state or country) Iowa
13a. FATHER'S NAME Unk		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Jessie G. Flynt (de)
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give dates of service) yes WWI		16. SOCIAL SECURITY NO. 491-10-8575	17. INFORMANT Address Robert Miller, St. Joseph, Mo
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 with Paroxysmal Atrial Tachycardia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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) Asthma			INTERVAL BETWEEN ONSET AND DEATH about 10 years
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.)	
20c. TIME OF INJURY Hour a.m. Month, Day, Year 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 Nov 1946 to June 26, 1957 and last saw him alive on 6/24/57 Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Thos Reimold MD (Degree or title)		22b. ADDRESS St Joseph, Mo	22c. DATE SIGNED 6/29/57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6/28/57	23c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery	23d. LOCATION (City, town, or county) (State) St. Joseph, Mo
24. FUNERAL DIRECTOR John E. [unclear] ADDRESS St. Joseph, Mo		25. DATE RECD. BY LOCAL REG. July 1, 1957	26. REGISTRAR'S SIGNATURE Mrs. Robert Fulton

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

JUL 5 1957

JUL 10 1957

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, ~~of~~, Student Embalmer No. working under my personal supervision.

Student Signature of Student Embalmer

Signed *John E. Rupp* Licensed Embalmer No. 3986 P. O. Address St. Joseph

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.