Health, Welfare Public Service

300 1-56 4

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

20544
STATE FILE NUMBER

FILED JUL 9 1957

Registration District No. 96 Primary Registration District No. 4158 Registrar's No. 62

1. PLACE OF DEATH
a. COUNTY: Dallas
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): Buffalo — Inside Limits Yes X No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give location): Washburn R.H. — Length of stay in 1b: 0300

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Dallas
c. CITY OR TOWN: Buffalo — Inside Limits Yes X No ☐
d. STREET ADDRESS (If outside, give location): West Commercial — Reside on Farm Yes ☐ No X

3. NAME OF DECEASED (Type or print): First Thomas Middle J. Last Flanagan

4. DATE OF DEATH: Month June Day 13 Year 1957

5. SEX: Male 0
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED X DIVORCED ☐ 2
8. DATE OF BIRTH: July 19, 1865
9. AGE (In years last birthday): 92
IF UNDER 1 YEAR / IF UNDER 24 HRS.: Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming
10b. KIND OF BUSINESS OR INDUSTRY: Own Farm
11. BIRTHPLACE (City and state or country): Dallas County, Mo. 0
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Flanagan
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service): unknown
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Bert Flanagan, Long Lane, Mo. (Address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 14 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerosis — ?
DUE TO (c): 4201
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senility

19. WAS AUTOPSY PERFORMED? YES ☐ NO X 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 1950 to 6-13-57 and last saw him alive on 6-13-57
Death occurred at 2:15 p. m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: C. O. Hammon (Degree or title) M.D. 0
22b. ADDRESS: Buffalo Mo.
22c. DATE SIGNED: 6-14-57

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 6-15-57
23c. NAME OF CEMETERY OR CREMATORY: Benton Branch
23d. LOCATION (City, town, or county) (State): Dallas County, Mo.

24. FUNERAL DIRECTOR: Jones of Buffalo, Mo. — ADDRESS
25. DATE RECD. BY LOCAL REG.: 7/8/57
26. REGISTRAR'S SIGNATURE: Mrs Grace Petree by

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

300

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.....gene C. Hunter

Licensed Embalmer No.....47

P. O. Address Buffalo

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.