

FILED JAN 13 1958

Registration District No. **318** Primary Registration District No. **1003**

S. 300
v. 1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) 25 St. Louis, OR TOWN Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis, Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION City Hospital		d. STREET ADDRESS (If outside, give location) 908 8549 Partridge	
3. NAME OF DECEASED (Type or print) First Middle Last JAMES J. FLYNN		4. DATE OF DEATH Month Day Year Dec. 21, 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 12, 1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Orderly		10b. KIND OF BUSINESS OR INDUSTRY St Vincent Hosp.	11. BIRTHPLACE (City and state or country) St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Michael Flynn	
13b. MOTHER'S MAIDEN NAME Mary Teefey		14. NAME OF HUSBAND OR WIFE Mary Flynn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes W.W.#1		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. George Fox-8549 Partridge Ave.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Heart Disease Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Generalized Arterio Sclerosis 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 checked="" 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.) 420.0	
20c. TIME OF INJURY Hour Month, Day, Year 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 _____ to _____ and last saw her/him alive on _____ Death occurred at 220 P. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE James M. Kelly (Deputy Registrar)		22b. ADDRESS 1300 Clark	
22c. DATE SIGNED 12-23-57		23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
23b. DATE 12/24/57		23c. NAME OF CEMETERY OR CREMATORY National Cemetery	
23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.		24. FUNERAL DIRECTOR ADDRESS Kriegshauser-4228 S.Kingshighway	
25. DATE RECD. BY LOCAL REG. DEC 23 57		26. REGISTRAR'S SIGNATURE J. Carl Smith Mo ms JB	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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
Licensed Embalmer No. 4533

P. O. Address

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.