

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-021269

STATE FILE NUMBER

FILED JUL 14 1958

Registration District No.

73

Primary Registration District No.

5291

Registrar's No.

100

1. PLACE OF DEATH a. COUNTY <b>Clay</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Clinton</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Liberty</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Trimble</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>I.O.O.F. Hosp.</b>		Length of stay in lb <b>3 Days</b>	d. STREET ADDRESS <b>2 miles East of Trimble</b>
			Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>Frank Flanary</b>			4. DATE OF DEATH Month Day Year <b>June 29, 1958</b>	
---	--	--	--	--

5. SEX <b>Ma</b>	6. COLOR OR RACE <b>Wh</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 21, 1871</b>	9. AGE (In years last birthday) <b>87</b>	IF UNDER 1 YEAR Months Days Hours Min. <b>1 8</b>	IF UNDER 24 HRS. Hours Min.
---------------------	-------------------------------	---	---	--	---	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	11. BIRTHPLACE (City and state or country) <b>Buchanan Co, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
--	--	--	--

13a. FATHER'S NAME <b>Frank Flanary</b>	13b. MOTHER'S MAIDEN NAME <b>Mary Nichols</b>	14. NAME OF HUSBAND OR WIFE <b>Anna L. Flanary</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>91-42-3579</b>	17. INFORMANT Address <b>Mrs. James Boyd Edgerton, Mo.</b>
--	--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>
DUE TO (b) <b>Arteriosclerosis</b>		
DUE TO (c) <b>331X</b>		
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 type="checkbox"/> NO <input checked="" 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.)
---	--

20c. TIME OF INJURY Hour Month, Day, Year o.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 Death occurred at <b>June 26 58</b> and last saw him alive on <b>June 28</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) <b>Albert H. Bradshaw M.D.</b>	22b. ADDRESS <b>Liberty Mo</b>	22c. DATE SIGNED <b>7-1-58</b>
---	-----------------------------------	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>7-1-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Davis Chapel Cemetery</b>	23d. LOCATION (City, town, or county) <b>Platte County, Missouri</b>
--	----------------------------	--	---

24. FUNERAL DIRECTOR <b>McComas Funeral Home</b>	ADDRESS <b>Smithville, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>7-5-58</b>	26. REGISTRAR'S SIGNATURE <b>Mabel Strahan</b>
---	-----------------------------------	---	---

(Licensed Embalmer's Statement on Reverse Side)

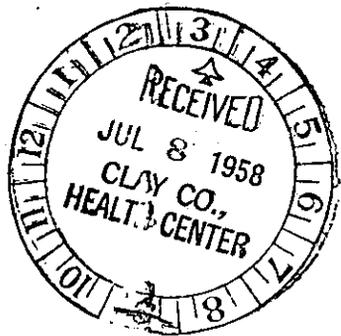
All diseases in Part I must be causally related. Use ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Info added by Jerry

JUL 8 1958

701-15-3224



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 *Donald W. Hanks* .....

Licensed Embalmer No. *4528*

P. O. Address *Smithville, Mo.*

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.