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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-007100

STATE FILE NUMBER 2 1484

FILED FEB 26 1959 Registration District No. ..... Primary Registration District No. ..... Registrar's No. .....

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS — Inside Limits Yes ☐ No ☐	c. CITY OR TOWN St. Louis. — Inside Limits Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) ST. LOUIS CITY HOSPITAL #1. — Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 4023 Olive St. — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print)	First: THOMAS	Middle: J.	Last: FLYNN	4. DATE OF DEATH Month 2 Day 9 Year 1959
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ 3 DIVORCED ☒	8. DATE OF BIRTH: July 13, 1904	9. AGE (In years last birthday): 54 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country): New Jersey	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME: Thomas J. Flynn Sr.	13b. MOTHER'S MAIDEN NAME: Ellen C. Ryan	14. NAME OF HUSBAND OR WIFE: 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.: Unknown	17. INFORMANT Address: Mrs. Genevieve Murphy, Moorestown, N.J.		

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) Lt anterior coronary artery old Chronic

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Myocardial infart old (septum).

DUE TO (c) Lungs. Congestion 420.1

INTERVAL BETWEEN ONSET AND DEATH

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 ☒ NO ☐

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 1-17-1959, to 2-9-1959 and last saw her/him alive on 2-9-1959

Death occurred at 6:45 p.m. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Robt. E. Stufflebam M.D.	22b. ADDRESS: 1515 LAFAYETTE AVE.	22c. DATE SIGNED: 2-9-1959
23a. BURIAL, CREMATION, REMOVAL (Specify): Removal	23b. DATE: 2-13-59	23c. NAME OF CEMETERY OR CREMATORY
23d. LOCATION (City, town, or county) (State): Moorestown, N.J.		
24. FUNERAL DIRECTOR ADDRESS: Albert H. Hoppe 4700 Washington, Blvd.	25. DATE RECD. BY LOCAL REG.: FEB 11 59	26. REGISTRAR'S SIGNATURE: Carl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 J. Wm Bussley

Licensed Embalmer No. 3653

P. O. Address [illegible]

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.