

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-015307

FILED VS. MAY 16 1960

149

Primary Registration District No. 1002 Registrar's No. 2373

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in lb <b>77 yrs.</b>	c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Plaza Nursing Home</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>8040 Summit</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>MRS. ELLEN FLYNN</b>			4. DATE OF DEATH Month <b>April</b> Day <b>27</b> Year <b>1960</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2-6-1871</b>	9. AGE (last birthday) <b>89</b>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>Lexington, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>Michael Kelly</b>		13b. MOTHER'S MAIDEN NAME <b>Sarah (Unknown)</b>		14. NAME OF HUSBAND OR WIFE <b>Peter Flynn-dec.</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>none</b>	17. INFORMANT Address <b>Mrs. Don A. Murphy 8040 Summit</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>Acute Cardiac Deception</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Acute Coronary Thrombosis</b>	<b>12 hours</b>
	DUE TO (c) <b>arteriosclerotic heart disease</b>	<b>years</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Frosted Hip - Oct - 6 week ago</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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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 _____ a.m. _____ p.m. Month, Day, Year _____			

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>Kansas City</b>	COUNTY <b>Jackson</b>	STATE <b>Missouri</b>
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21. I attended the deceased from **1960-Feb.** to **4-27-60** and last saw her alive on **4-24-60**  
Death occurred at **7 AM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>John T. Skinner MD</b> (Degree or title)	22b. ADDRESS <b>1102 Grand St. CMO</b>	22c. DATE SIGNED <b>4-27-60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>4-29-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City, Missouri</b>
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24. FUNERAL DIRECTOR <b>Melody McGilley-Eylar</b>	ADDRESS <b>1800 E. Linwood Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>4-28-60</b>	26. REGISTRAR'S SIGNATURE <b>Reva Minshall</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

John T. Skinner

- FLY 13 -

D. J. T. Sk  
Bryant B.

V12-7010

about 2 p

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Arthur Eugene

Licensed Embalmer No. 4573

P. O. Address KO 7th

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.