

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-047168

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 3664

FILED JAN 9 1962

1. PLACE OF DEATH a. COUNTY <u>St Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>St Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clayton</u>		Length of stay in lb <u>DOA</u>	c. CITY OR TOWN <u>St John</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Louis Co Hosp</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>8584 North Ave</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>Catherine Flynn</u>			4. DATE OF DEATH Month Day Year <u>12/23/61</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3/2/1893</u>	9. AGE (last birthday) <u>68</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (City and state or country) <u>Scotland</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>William Barr</u>	13b. MOTHER'S MAIDEN NAME <u>Do Not Know</u>	14. NAME OF HUSBAND OR WIFE <u>James Flynn</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	17. INFORMANT Address <u>James Flynn 8584 North</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c). DEATH WAS CAUSED BY: PART I. IMMEDIATE CAUSE (a) <u>Skull fracture and brain injury</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____		
DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N: <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 checked="" type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Passenger involved in 2 car collision</u>
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20c. TIME OF INJURY: Hour <u>1:20</u> Minute <u>00</u> p.m. <u>12/23/61</u>
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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.) <u>highway</u>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>St. Louis Missouri</u>
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21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
Death occurred at \_\_\_\_\_ P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Raymond H. [Signature]</u> Coroner	22b. ADDRESS <u>Clayton, Mo.</u>	22c. DATE SIGNED <u>12/30/61</u>
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23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12/26/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Ferdinand Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Florissant Mo.</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Ortmann F Home 9222 Lackland Overland Mo</u>	25. DATE RECD. BY LOCAL REG. <u>12-23-61</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

**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 Al C. Outmann

Licensed Embalmer No. 3478

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.