

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

26752

1. PLACE OF DEATH

County Jackson Registration District No. 300
Township Kaw Primary Registration District No. 1002
City Kansas City (No. Research Hospital 1002)

File No. _____
Registered No. 3357 (Ward) 13

2. FULL NAME Maurice Sheehan

(a) Residence, No. 3441 Woodland St., 13 Ward. (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs. Margaret Sheehan

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 26 1861

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
68 3 15

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. K. C. Water Dept
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

10. NAME OF FATHER Dennis Sheehan

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ireland

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Not Known

14. INFORMANT Mrs Margaret Sheehan (Address) 3441 Woodland

15. FILED 8/2/30 M. M. Crowe REGISTRAR

2) MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 11 1930¹⁹

17. I HEREBY CERTIFY, That I attended deceased from Aug 8, 1930 to Aug 10, 1930 that I last saw him alive on Aug 10, 1930 and that death occurred, on the date stated above, at 6:45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral hemorrhage
32A
97 (duration) yrs. mos. 3 ds.

CONTRIBUTORY (SECONDARY) Subintentional strokes (duration) 5 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 74th St
IF NOT AT PLACE OF DEATH

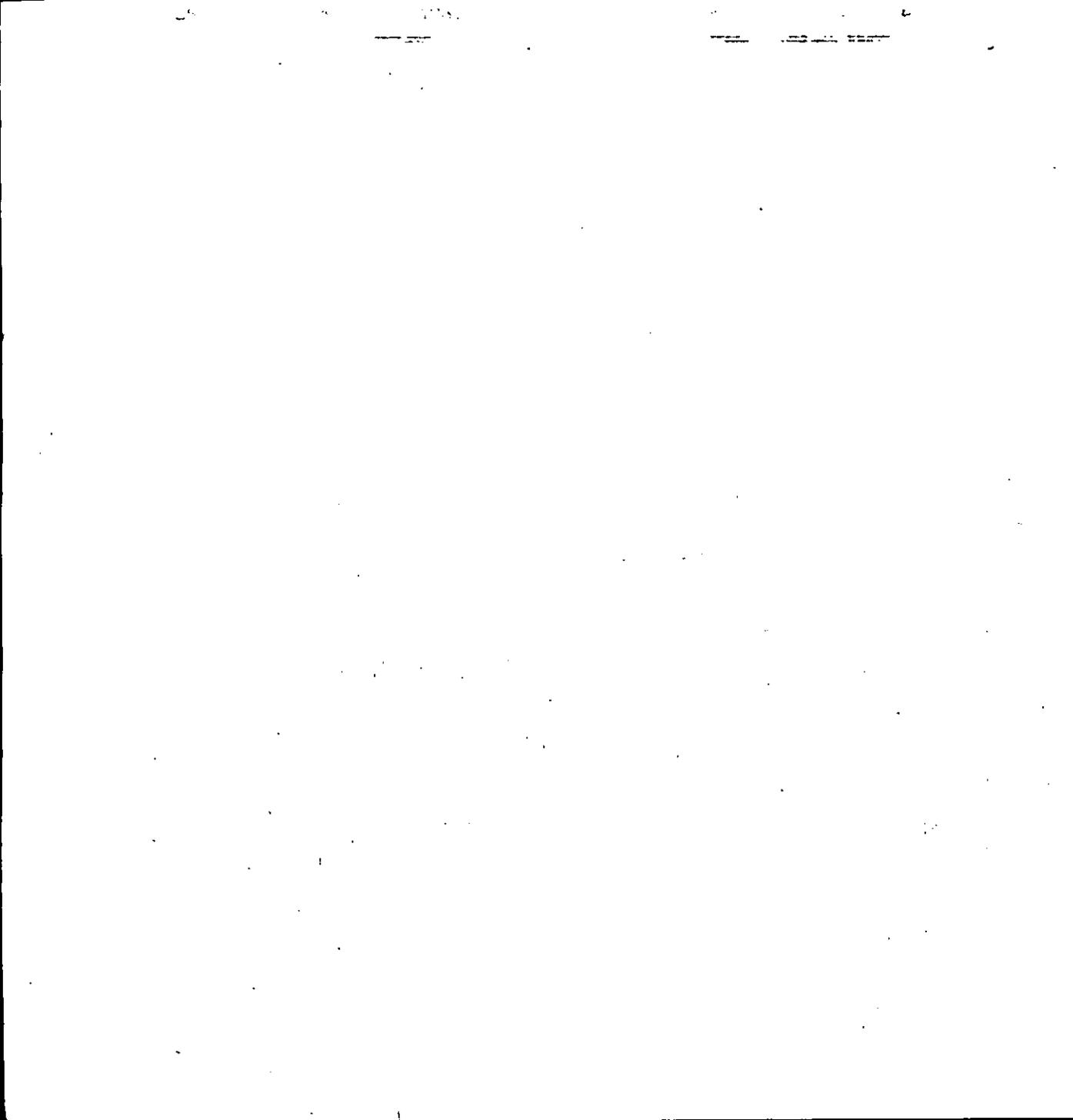
19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

20. WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Blood pressure
Detention records
(Signed) Pearson, M. D.

Aug 11 1930 (Address) 400 1/2 Maple
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL St. Mary's Cemetery DATE OF BURIAL Aug 13 1930

20. UNDERTAKER Quirk & Tobin--20 W Linwood ADDRESS K. C. Mo.



**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County..... Registration District No. 399 File No.
 Township..... Primary Registration District No. 1002 Registered No. 3357
 City N. City (No.) St. Ward (No.)

2. FULL NAME

(a) Residence. No. Maurice Sheehan St. Ward.
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED M
 (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 26-1862

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
68 3 13

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14.

INFORMANT (Address)

15.

FILED

8/2/30 M. M. Brown
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 11 1930

17. I HEREBY CERTIFY, That I attended deceased from to 19....., 19....., and that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

REGISTRARS USE ONLY FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-26752