

REC'D JUN 9 1938

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

16310

Do not use this space.

1. PLACE OF DEATH

(a) County.....

(b) Township.....

(c) City..... St. Louis

Registration District No. 1003

Primary Registration District No.

(d) Street No. City Hospital No. 1 Registered No. 4171

(If death occurred in Hospital or Institution, write its name instead of street and number)

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

D. 17475

2. PRINT FULL NAME

(a) Residence, No. 8520 Water St. 11 (If nonresident, give city or town and State)

(Usual place of abode, if no street address, write county or city)

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED, OR
DIVORCED (write the word)
married5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 2, - 1888

7. AGE

YEARS 49

MONTHS 5

DAYS 4

If LESS than 1
day, hrs.
or min.

OCCUPATION

8. Trade, profession, or particular kind of
work done, as sawyer, bookkeeper, etc.9. Industry or business in which work
was done, as saw mill, bank, etc.

machinist

10. Date deceased last worked at
this occupation (month and
year)11. Total time (years)
spent in this
occupation12. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

St. Louis, Missouri

13. NAME

William Sheehan

14. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

Ireland

15. MAIDEN NAME

Helen Schneck

16. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

Germany

17. INFORMANT
(ADDRESS)

Hosp. Info M. Kent

18. BURIAL, CREMATION, OR REMOVAL

PLACE St. Paul's Church DATE May 9 1938

19. FUNERAL DIRECTOR (NAME)
(ADDRESS)Frank R. Ralte
7420 Michigan Ave20. FILER
MAY - 6 1938J. G. Bredeck
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5/6/38, 19

22. I HEREBY CERTIFY, That I attended deceased from
2/28/38, 19, to 5/6/38, 19.

I last saw him alive on 5/6/38, 19. Death is said

to have occurred on the date stated above, at 7 a.m.

The principal cause of death and related causes of importance were as follows:

Pulmonary tuberculosis

Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?.....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?

If so, specify.....

(Signed) Wm. D. Bredeck, M. D.

(Address) City Hospital N. 1

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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 _____,
Registered Apprentice No. _____, working under my personal supervision.

Signed *Harry J. Schumacher*

Licensed Embalmer No. *2679 -*

P. O. Address *744 Gering Ave*

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 this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

16310
Do not use this space.

1. PLACE OF DEATH
 (a) County St Louis Registration District No. 791
 (b) Township _____ Primary Registration District No. 1003 Registered No. 4171
 (c) City St Louis (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME John Sheehan
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED m

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF LOUISE SHEEMAN

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>49</u>	<u>5-</u>	<u>4</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____

9. Industry or business in which work was done, as saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____

11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

FATHER

13. NAME _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER

15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19 _____

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED JUL 23 1938 19 _____ J. D. Budick Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-16, 1938

22. I HEREBY CERTIFY, That I attended deceased from _____ 1938 to _____ 19____.

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows: _____

Date of onset _____

Other contributory causes of importance: _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) Wm F. Friedewald, M. D.
 (Address) City Hosp # 1

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

S-16310 1938