S. No. 2
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FILED OCT 11 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31024

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 3587

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 3409 Wyandotte
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 (Specify whether
In this community Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits write "RURAL")

(d) Street No. 0 3409 Wyandotte
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME MARY A. SHEEHAN

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife --

6. (c) Age of husband or wife if alive -- years

7. Birth date of deceased about 1863 (Month) (Day) (Year)

8. AGE: Years 77 Months -- Days -- If less than one day ____ hr. ____ min.

9. Birthplace Montgomery County (City, town, or county) Missouri (State or foreign country) 0

10. Usual occupation Retired--Rooming House 5

11. Industry or business Operator

FATHER
12. Name Dennis Sheehan 5
13. Birthplace (City, town, or county) Ireland (State or foreign country)

MOTHER
14. Maiden name Katherine O'Connor
15. Birthplace (City, town, or county) Ireland (State or foreign country)

16. (a) Informant Mrs. H. J. Holmes
(b) Address Phoenix, Arizona

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/14/40 (Month) (Day) (Year)
(c) Place: burial or cremation St. Marys' Cemetery

18. (a) Signature of funeral director Turk & Tobin Co.
(b) Address 20 W. Linwood

19. (a) Sept. 13, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month ____ day 9-10-40
year ____ hour ____ minute ____ A.M.

21. I hereby certify that I attended the deceased from 9:30 A. ____, 19__, to ____, 19__;
that I last saw ____ alive on ____, 19__;
and that death occurred on the date and hour stated above.

Immediate cause of death Deputy Coroner

Duration

Alute pulmonary edema

Due to Chronic myocardial infarction

Due to Coronary sclerosis

Other conditions
(Include pregnancy within 3 months of death) 94B

Major findings:
Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury 5

23. Signature [signature] (M. D. or other)
Address K. C. Mo. Date signed

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

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