

Registration District No. \_\_\_\_\_

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Jewish Hosp  
(If not in hospital or institution, write street number or location) 0  
(d) Length of stay: In hospital or institution 9 Wks (Specify whether \_\_\_\_\_)  
In this community Life  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County 22  
(c) City or town ST. LOUIS (If outside city or town limits, write "RURAL") MO  
(d) Street No. 11 So 4th St (If rural, give location) 17  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) 0  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

SHEEHY, WILLIAM

3. (b) If veteran, name war No 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced 3 divorced Divorce

6. (b) Name of husband or wife Adele Sheehy 6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased: JULY 9 1888  
(Month) (Day) (Year)

8. AGE: Years 55 Months 11 Days 1 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace: St. Louis Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation: Guard Mc Quay Norris Co

11. Industry or business: Mc Quay Norris

MOTHER FATHER

12. Name: Edward Sheehy

13. Birthplace: Connecticut  
(City, town, or county) (State or foreign country)

14. Maiden name: Katherine Brown

15. Birthplace: St. Louis Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant: Corline Klinkhardt

(b) Address: 5556 Lansdown Ave

17. (a) Burial (b) Date thereof: 6 12 44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Calvary Cem

18. (a) Signature of funeral director: Kriegshauser Und Co

(b) Address: 4228 So. Kingshighway

19. (a) JUN 11 1944 (b) J. F. Bredeck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 10  
year 1944 hour 7 minute 30 A.M.

21. I hereby certify that I attended the deceased from 4/20/44  
\_\_\_\_\_ 19\_\_\_\_, to 6/10 1944  
that I last saw him alive on 6/9/44 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death: Post operative  
Duration: 2 days

Due to: adhesive arachnoiditis of cervical spinal cord ?

Due to: \_\_\_\_\_  
Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: adhesive arachnoiditis of cervical spinal cord  
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 \_\_\_\_\_

23. Signature: Joseph O'Keefe (M.D. or other) MD  
Address: 462 N. Taylor Date signed: 6/10/44

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

**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 *Edwin D. Mc Dermott*

Licensed Embalmer No. *3024*

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, fact should be so stated above.**