

Registration District No. **818**

Primary Registration District No. **1003**

State File No.

Registrar's No. **6794**

1. PLACE OF DEATH:
 (a) County.....
 (b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
5010 A. Northland Ave. /
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution.....
(Specify whether
 In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County.....
 (c) City or town St. Louis
(If outside city or town limits, write "RURAL")
 (d) Street No. 5010 A. Northland Ave.
(If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME Anna O'Shea
 3. (b) If veteran, name war..... 3. (c) Social Security 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 Dont Know 1879
(Month) (Day) (Year)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Aug. day 2 year 1944 hour 11 minute A. M.
 21. I hereby certify that I attended the deceased from July 31 1944 to Aug - 2 1944
 that I last saw her alive on Aug - 2 1944
 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
65 Unknown hr. min.

Immediate cause of death Intestinal Stasis -
 Due to... Intestinal tumor
unqualified
 Due to...
 Other conditions (Include pregnancy within 3 months of death) 57e1

9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)
 10. Usual occupation Public School Teacher

Major findings: Of operations non
 Of autopsy non
PHYSICIAN
 Underline the cause to which death should be charged statistically.

MOTHER FATHER
 11. Industry or business.....
 12. Name Nicholas O'Shea
 13. Birthplace Ireland 4
(City, town, or county) (State or foreign country)
 14. Maiden name Anna Markham
 15. Birthplace Ireland 4
(City, town, or county) (State or foreign country)

16. (a) Informant Lawrence A. Tobin
 (b) Address 5010 A. Northland Ave.
 17. (a) Burial (b) Date thereof 8-5-44
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Calvary Cemetery
 18. (a) Signature of funeral director Arthur J. Donnelly
 (b) Address 3840 Lindell Blvd.
 19. (a) AUG 3 1944 (b) J. F. Beedack
(Date received local registrar) (Registrar's signature)

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?
 While at work?..... (Specify type of place)
 (e) Means of injury.....
 23. Signature J. F. Beedack (M. D. or other).....
 Address 2122 S. Grand Bl. Date signed 8-24-44

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

Dr Link
3550 Richmond

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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 Stanley Marshall
Licensed Embalmer No. 2868
P. O. Address 3840 Lindell

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.