

FILED JAN 20 1948

Registration District No. **149** Primary Registration District No. **1002**

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:
1824 SUMMIT
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days) **40 YEARS**

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. **1824 SUMMIT**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME **WILLIAM JAMES SHEAHAN**

3. (b) If veteran, name war **NONE**

3. (c) Social Security No. **487-26-5908**

4. Sex **MALE** 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 **SEPTEMBER 18 1890**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	57	3	15	hr. _____ min.

9. Birthplace **MONTSERRAT MISSOURI**
(City, town, or county) (State or foreign country)

10. Usual occupation **EMPLOYEE--BURLINGTON FREIGHT**

11. Industry or business **HOUSE**

MOTHER FATHER

12. Name **WILLIAM J. SHEAHAN**

13. Birthplace **COUNTY CORK IRELAND**
(City, town, or county) (State or foreign country)

14. Maiden name **CATHERINE J. SHERREN**

15. Birthplace **JACKSONVILLE ILLINOIS**
(City, town, or county) (State or foreign country)

16. (a) Informant **MISS NORA SHEAHAN**

(b) Address **1824 SUMMIT**

17. (a) **BURIAL** (b) Date thereof **1-7-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **MT. ST. MARY'S CEMETERY**

18. (a) Signature of funeral director **J. F. Donnell**

(b) Address **3256 BROADWAY**

19. (a) **1-5-48** (b) **Sheraldine Holmes**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **JANUARY** day **3** year **1948** hour **9** minute **P.** M.

21. I hereby certify that I attended the deceased from **Dec 20**, 19**47**, to **Jan 3**, 19**48**, that I last saw him alive on **Jan 3**, 19**48** and that death occurred on the date and hour stated above.

Immediate cause of death **Lobar Pneumonia** Duration **4 days**

Due to _____

Due to _____

Other conditions **Chs Myocarditis**
(Include pregnancy within 3 months of death)

Major findings:
Of operations **108**

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature **C. M. Council MD** (M. D. or other)

Address **708 W 17th St** Date signed **1/5/48**

C.M. COUNSELL
708 WEST 17

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..... *Park G. Rowe*

..... Licensed Embalmer No. *2349*

..... P. O. Address..... *71 C. Me.*

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.