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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED NOV 1 1948

Registration District No. 37

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5227

State File No. 32302

Registrar's No. 189

1. PLACE OF DEATH:
(a) County: Cass
(b) City or town: Rural Harrisonville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: County Home 5
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 2 years (Specify whether years, months or days)
In this community:

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Cass 19
(c) City or town: Rural
(If outside city or town limits, write "RURAL")
(d) Street No.: 4
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: JOHN WILLIAM SHEEHAN
3. (b) If veteran, name war: —
3. (c) Social Security No.: —

4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Widowed
6. (b) Name of husband or wife: Sarah Sheehan
6. (c) Age of husband or wife if alive: Dec'd years
7. Birth date of deceased: April (Month) 10 (Day) 1859 (Year)

8. AGE: Years 89 Months 6 Days 10 If less than one day hr. min.

9. Birthplace: Unknown (City, town, or county) (State or foreign country)
10. Usual occupation: Retired farmer
11. Industry or business:
FATHER 12. Name: Un Known
13. Birthplace: Un Known (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name: Un Known
15. Birthplace: Un Known (City, town, or country) (State or foreign country)
16. (a) Informant: Mrs. Shirley Feeback
(b) Address: Belton Mo.
17. (a) ~~Wea Kans.~~ Burial (Burial, cremation, or removal) (b) Date thereof: Oct. 22-48 (Month) (Day) (Year)
(c) Place: burial or cremation: Wea Kansas
18. (a) Signature of funeral director: Geo. E. Myers
(b) Address: Cleveland Mo.
19. (a) Oct. 25, 1948 (Date received local registrar) (b) Laura J. Jones (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 20 year 1948 hour 3: minute 4 A.M.
21. I hereby certify that I attended the deceased ~~from~~ only on Oct. 19, 1948 to 19 that I last saw him alive on Oct. 19 1948 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Mitral Regurgitation	
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

Major findings:
Of operations: B
Of autopsy: NP

PHYSICIAN — Underline the cause of 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: 0
23. Signature: J. S. Triplett M.D. (M. D. or other)
Address: Harrisonville Mo. Date signed 10-21-48

Jefferson City Printing Co.

(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 Geo. E. Myers

Licensed Embalmer No. 2517

P. O. Address Cleveland Mo

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.