

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **16100**

Dr. D. Hall

FILED JUN 11 1956

Registration District No. **128** Primary Registration District No. **2000** Registrar's No. **519**

1. PLACE OF DEATH a. COUNTY Greene			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Springfield		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hosp.			Length of stay in 1b Life	d. STREET ADDRESS 607 W. Lynn	
3. NAME OF DECEASED (Type or print) First John Middle F. Last Shea			4. DATE OF DEATH Month June Day 5 Year 1956		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 2 1880	9. AGE (In years last birthday) 75
IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Shea & Morris		10b. KIND OF BUSINESS OR INDUSTRY Monument Co.	11. BIRTHPLACE (City and state or country) Lebanon, Missouri		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Cornelius Shea			14. MOTHER'S MAIDEN NAME Mary Ellen Quinn		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ?	17. INFORMANT Mrs. Ida Shea		Address Springfield, Mo.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hyostatic pneumonia--terminal					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					3 weeks
DUE TO (b) Uremia					
DUE TO (c) Left hydronephrosis					3 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Left hemiplegia, progressive complete					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 601x		
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION		COUNTY STATE
21. I attended the deceased from May 2, 1956 to June 5, 1956 and last saw her him alive on June 5, 1956 Death occurred at 6:10 a. m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Dr. D. Hall M.D. (Degree or title)			22b. ADDRESS 1211 S. Glenstone Springfield, Missouri		22c. DATE SIGNED June 5, 56
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6/7/56	23c. NAME OF CEMETERY OR CREMATORY Eastlawn		23d. LOCATION (City, town, or county) (State) Springfield, Mo.	
24. FUNERAL DIRECTOR H.H. Lohmeyer		ADDRESS Springfield, Mo.	25. DATE RECD. BY LOCAL REG. 6-8-56	26. REGISTRAR'S SIGNATURE John W. Bowman	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Disseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

FEB 7 1954

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *H. M. Carr*.....

Licensed Embalmer No. *2*.....

P. O. Address *Spring*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.