

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11069
STATE FILE NUMBER
3009
Registrar's No.

FILED APR 15 1957

Registration District No. 318 Primary Registration District No. 1003

Health,
Welfare
Public
Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

| | | | | | | | |
|---|---------------------------|---|--|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 812 Geyer | | | Length of stay in lb | | d. STREET ADDRESS 812 Geyer (If outside, give location) | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last PATRICK C. SHEEHAN | | | | 4. DATE OF DEATH Month Day Year 3 24 1957 | | | |
| 5. SEX Male <input type="checkbox"/> Female <input checked="" type="checkbox"/> | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 11-25-1878 | | 9. AGE (In years last birthday) 78 | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hospital Attendant | | 10b. KIND OF BUSINESS OR INDUSTRY Retired | | 11. BIRTHPLACE (City and state or country) Ireland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME James Sheehan | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown | | 16. SOCIAL SECURITY NO. — | | 17. INFORMANT Address Glenda Sheehan, 812 Geyer | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Corbice Bronchitis & Edema</i> DUE TO (b) <i>Senility</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 434.2 | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 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.) | | | | |
| 20c. TIME OF INJURY Hour 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 1-1-57 to 3-24-57 and last saw her/him alive on 3-23-57 Death occurred at 8-P m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) <i>L. F. Murray M.D.</i> | | | | 22b. ADDRESS 605-A-Russell | | 22c. DATE SIGNED 3-28-57 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. NAME OF CEMETERY OR CREMATORY St. Trinity Cemetery | | 23c. LOCATION (City, town, or county) (State) St. Louis Co., Missouri | | | |
| 24. FUNERAL DIRECTOR McLAUGHLIN'S, 2301 Lafayette | | ADDRESS | | 25. DATE RECD. BY LOCAL REG. MAR 28 '57 | | 26. REGISTRAR'S SIGNATURE <i>Carl Smith M.D.</i> acm | |

(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, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *James R. Chapman*.....
Licensed Embalmer No. *4560*.....

P. O. Address *St. Louis, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.