MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

16383

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 4268

City St Louis Mo (No. 5075 Clayton Ave St. ..... Ward)

2. FULL NAME Charles J. Sheehan

(a) Residence. No. 5075 Clayton Ave St., 7 Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Elizabeth Sheehan

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 26 - 1863

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	64	—	8	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Complaint Man

(b) General nature of industry, business, or establishment in which employed (or employer) Laclede Gas Co.

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St Louis Ave.
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Michael Sheehan

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ireland
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Dont know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ireland
(STATE OR COUNTRY)

14. INFORMANT Elizabeth Sheehan
(Address) 5075 Clayton Ave.

15. FILED ..... 19.. Max C Starkeoff
REGISTRAR

3

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 4th 1927

17. I HEREBY CERTIFY, That I attended deceased from Feb. 24, 1926, to May 4, 1927, that I last saw him alive on May 3, 1927, and that death occurred, on the date stated above, at 11 30 AM m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage (Apoplexy)
131
42 B
109 (duration) yrs. mos. 2 ds.

CONTRIBUTORY (SECONDARY) Chronic Interstitial Nephritis with Arterial Hypertension
(duration) 5 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 12 9 A
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? No. DATE OF .....
WAS THERE AN AUTOPSY? No.
WHAT TEST CONFIRMED DIAGNOSIS? Physical Examination

(Signed) A. R. Shuffle, M. D.
5/5, 1927 (Address) 1021 Missouri Bldg. St. Louis

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Bethania	May 6 1927
20. UNDERTAKER	ADDRESS 1417
Hy Leidner Und Co	N. Market

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PERMANENT RECORD