

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

Do not use this space.

26520

1. PLACE OF DEATH
 County Buchanan Registration District No. 85
 Township Washington Primary Registration District No. 1001
 City St. Joseph (No. _____) St. _____ Ward _____

2. FULL NAME Anna Blake Sheehan
 (a) Residence No. 229 So. 12th St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 50 yrs. # 4 mos. # 4 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) About 1837

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
90 Widow

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work At Home 186A
 (b) General nature of industry, business, or establishment in which employed (or employer) 194B
43C
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Lisgow
 (STATE OR COUNTRY) Ireland

10. NAME OF FATHER John Blake

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

12. MAIDEN NAME OF MOTHER Anna Quirk

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

14. INFORMANT Mr. John Boyer
 (Address) St. Joseph Mo.
 SEP 9 1927
 FILED John G. [unclear]
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 7th 1927

17. I HEREBY CERTIFY, That I attended deceased from Sept 6, 1927, to Sept 7, 1927, that I last saw her alive on Sept 7, 1927, and that death occurred, on the date stated above, at 7:20 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Fracture of Left Femur.

Fall on Floor (Accidental)
 (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) Myocarditis - Chronic
Sensility (duration) 2 yrs. _____ mos. _____ ds.

18. WHERE WAS DECEASED CONTRACTED? _____
 NOT AT PLACE OF DEATH.
 Did AN OPERATION PRECEDE DEATH? no. DATE OF _____
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) H. G. Thompson Jr., M.D.
9/7, 1927 (Address) 825 Charles St. - St. Joseph
 *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 St. Olivet Cemetery DATE OF BURIAL Sept 9 1927

20. UNDERTAKER Rock Funeral Home - 906 S. 12th St.
By J. AMOLES MGR.

WRITE PAINLY, WITH UNFADING INK...THIS IS A PERMANENT RECORD

WARNING - RESERVED FOR BINDING

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.

CT 2 1927

