

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

Do not use this space.

14387

1. PLACE OF DEATH

County Lake Registration District No. 689
 Township Buffalo Primary Registration District No. 5917
 City (No. passing through) St. _____ Ward _____

2. FULL NAME

(a) Residence. No. Leah Sheedy St. _____ Ward _____
 (Usual place of abode) Ewing Mo (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

MEDICAL CERTIFICATE OF DEATH

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) ~~4/18~~ 4/18 1928

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

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at midnight m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 10/12/1903

THE CAUSE OF DEATH* WAS AS FOLLOWS:
accidental drowning

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ____ hrs. or ____ min.
24 | 6 | 6

183/82
CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

8. OCCUPATION OF DECEASED Student & Steam Boat Deck hand
 (a) Trade, profession, or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH, _____

9. BIRTHPLACE (CITY OR TOWN) Philadelphia
 (STATE OR COUNTRY) Tenn

DID AN OPERATION PRECEDE DEATH, _____ DATE OF _____
 WAS THERE AN AUTOPSY, _____

10. NAME OF FATHER Dennis A Sheedy

WHAT TEST CONFIRMED DIAGNOSIS:
 (Signed) C. W. Davis, Coroner
5/19, 1928 (Address) Bowling Green MO

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Lewis Co
 (STATE OR COUNTRY) Mo

12. MAIDEN NAME OF MOTHER Katie McDonald

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

*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.

14. INFORMANT Dennis A Sheedy
 (Address) Ewing Mo

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Ewing Mo DATE OF BURIAL 5/21 1928

15. FILED 5/19, 1928 F. J. Taylor REGISTRAR

20. UNDERTAKER J. Chalup ADDRESS Louisiana, Mo

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.

28-4-18
 10-12
 24-6-6

the original

note you ~~had~~ have

death (4/18 - 28)

of burial 5-21-28)

Don't return.

Who drowned
in 4/19. Body not
found until 5/19
at 121-
ent 5/19

S-14387
1428

622

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

(4 or 5 - 28)
ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Dike
Township Buffalo
City Buffalo (No.)

Registration District No. 689
Primary Registration District No. 3-9-17

File No. 14387
Registered No.
St. Ward

2. FULL NAME

(a) Residence. No. St. 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S (after the word)

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

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

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

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

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

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT (Address)

15. FILED 5-21-28 H.C. Haley Jr REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-18-28

17. I HEREBY CERTIFY That I attended deceased from 19..... that I last saw him alive on 19..... and that death occurred, on the date stated above, m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)..... M. D.

, 19 (Address)

*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

20. UNDERTAKER

H.C. Haley Jr ADDRESS Lam Mo

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-14387