

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

Do not use this space.

FEB 5 1929
5237

1. PLACE OF DEATH

County Washington
Township Union
City (No.) St. Ward

Registration District No. 887
Primary Registration District No. 6182

File No.
Registered No. 16
St. Ward

2. FULL NAME

Bridget Sheehan

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 10-19-1853
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
74 2 23

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

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

10. NAME OF FATHER Eli Boyer

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

12. MAIDEN NAME OF MOTHER Mary Boyer

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

14. INFORMANT Joe Sheehan
(Address) Cadet R.R. #1 Mo

15. FILED 1/12 1929 Jos. L. Thurman
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-12 1929

17. I HEREBY CERTIFY That I attended deceased from 1-9 1929 to 1-12 1929, and that I last saw her alive on 1-11 1929, and that death occurred, on the date stated above, at 11:50 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

11A Broncho-pneumonia
107A

110W Influenza (duration) yrs. mos. 6 da.
CONTRIBUTORY (SECONDARY) Influenza (duration) yrs. mos. 9 da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? —

18 DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Joseph L. Thurman, M.D
1/2 1929 (Address) Potosi, Mo.

*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

Olemiss Mo 1-14 1929

20. UNDERTAKER

J.B. Boyer & Son ADDRESS Potosi Mo

110
0
0
74-
235
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.

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

ALL INFORMATION CONTAINED
HEREIN MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
 County Washington Registration District No. 887 File No.
 Township Union Primary Registration District No. 6182 Registered No. 6
 City (No.) St. Ward

2. FULL NAME Bridget Thebean
 (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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 10-19-1853

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
75 2 23

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)

4.

INFORMANT
 (Address)

15. FILED 4/10/29 Jos. L. Thurman
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 2 1929

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

19

20. UNDERTAKER

ADDRESS

Information should be carefully supplied. AGE should be stated. ACTUALLY. PHYSICIANS terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-5207