

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

Do not use this space.

19882

File No. 5504

Registered No. 5504

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis (No. St. Lukes Hospital) St. _____ Ward _____

2. FULL NAME

William B. McShane
 (a) Residence. No. 5575 Waterman St., 5 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 male **4. COLOR OR RACE** white **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY AND YEAR) abt. 1871
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
abt. 58 unknown
8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Janitor
 (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)

Ill.
10. NAME OF FATHER Barney McShane
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ireland
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown

14. INFORMANT Jillie Banks
 (Address) 3711 Pageer Beach
15. FILED MA 18 1929 Wm. A. Stanley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 17 1929
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 _____, _____, _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Shock from Anesthesia
Fractured Femur
Struck by Auto
CONTRIBUTORY (SECONDARY) St. Louis, Mo.
Accident

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH, _____
 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? yes
 WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) J. W. Kerney, M.D.
5/18, 1929 (Address) Dep. Coroner

*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 Calvary Cem. **DATE OF BURIAL** 5/20 1929
20. UNDERTAKER Arthur J. Donnelly **ADDRESS** 2039 West 11

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.

WRITE IN PENCIL; WITH UNFADING INK—THIS IS A PERMANENT RECORD

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Levenson office