

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

Do not use this space.

JUN 4 1935

18592
KCP

1. PLACE OF DEATH
 County St. Louis Registration District No. 1170
 Township Central Primary Registration District No. 6248H
 City Richmond Hts., Midway, Clayton & Lindberg St. _____ Ward) _____
 2. FULL NAME Simon Shea
 (a) Residence, No. Clayton & Lindberg St., _____ Ward. Clayton P. O.
 (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

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 19

7. AGE YEARS 67 MONTHS 9 DAYS 18 If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Gardener
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

MOTHER
 13. NAME Simon Shea
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland
 15. MAIDEN NAME Hannah Grogan
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

FATHER
 17. INFORMANT Hannah Grogan
 (ADDRESS) Clayton & Lindberg
 18. BURIAL, CREMATION, OR REMOVAL PLACE Calvary Church DATE 5-10-35
 19. UNDERTAKER Lucia H. Bopp
 (ADDRESS) Richmond Hts.
 20. FILED 5/8 1935 Gertrude Porter
 Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-7-1935

22. I HEREBY CERTIFY, That I attended deceased from April 3 - 1935, to May 7 1935
 I last saw him alive on May 7 - 10 40 1935 Death is said to have occurred on the date stated above, at 10 40 am.
 The principal cause of death and related causes of importance were as follows:
Bronchial Pneumonia - Date of onset May 5
Chronic Nephritis -
Chronic Myocarditis - 4-3-35
 Other contributory causes of importance:
No -
 Name of operation No - Date of _____
 What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? No Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
 Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify _____
 (Signed) Ray A. Walker, M. D.
 (Address) 2438 Woodson Rd. Overland, Mo.

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