

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

Do not use this space.

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis Children's Hospital**

File No. **17877**

Registered No. **4670**

St. Ward)

2. FULL NAME **James Joseph Shea**

(a) Residence, No. **R #2 ~~St. Louis~~**

St. **NR** Ward. **Junction, Ill**

(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 (write the word)

Child

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

Child.

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

1-20-36

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

3

9

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

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

Child.

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

Junction, Ill

FATHER

13. NAME **George SHEA.**

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

Ill.

MOTHER

15. MAIDEN NAME **Anna Mary McDonald**

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

Ill.

17. INFORMANT (ADDRESS)

J. M. S. Silver, SW 2, Kingshighway

18. BURIAL, CREMATION, OR REMOVAL

PLACE **Shammetown, Ill** DATE **4-29-36**

19. UNDERTAKER (ADDRESS)

GEORGE SHEA (FATHER), JUNCTION, ILL.

20. FILER

J. J. Bredeck

Registrar.

APR 29 1936

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **4-29-36**, 19..

22. I HEREBY CERTIFY, That I attended deceased from **4-17-36**, 19.., to....., 19..

I last saw him/her alive on **4-29-36**, 19.. Death is said to have occurred on the date stated above, at **3:12** m.

The principal cause of death and related causes of importance were as follows:

**Brain typhoid - Meningococci
Hydrocephalus
Pneumonia
Bronchial**

Date of onset
**1/20/36
4/21/36
4/27/36**

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy? **Yes**

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?..... 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?.....

If so, specify.....

(Signed) **Robert S. Smith**, M. D.

(Address) **Barnes Hospital**

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.

