

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Registration District No. 7201

Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH: 1008 PLM FES

(a) County \_\_\_\_\_

(b) City or town St. Louis

(c) Name of hospital or institution: DePaul Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution one day  
In this community 19 years. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 4477 Washington Blvd.  
(If rural, give location)

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Helen Cadle Shea 0090

8. (b) If veteran, name war none

8. (c) Social Security No. none

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife John Shea

6. (c) Age of husband or wife if alive 32 years

7. Birth date of deceased Sept. 16, 1907  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>32</u>	<u>3</u>	<u>28</u>	hr. _____ min.

9. Birthplace Sedalia, Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Housework

11. Industry or business Home

MOTHER FATHER

12. Name Michael W. Cadle

18. Birthplace Gladstone, Illinois  
(City, town, or county) (State or foreign country)

14. Maiden name Mary E. McHally

15. Birthplace Sedalia, Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature John W Shea

(b) Address 4477 Washington Blvd.

17. (a) Burial (b) Date thereof Jan. 17.40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Salvary Cemetery

18. (a) Signature of funeral director Bansick-Michau

(b) Address 1431 Union Blvd.

19. (a) JAN 16 1940 (b) \_\_\_\_\_  
(Date received local registrar) (Date of death)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 14  
year 1940 hour 5 minute 35 P. M.

21. I hereby certify that I attended the deceased from July 10  
1939 to Jan 14 1940  
that I last saw her alive on July 1, 1940 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Post Partum Bleeding

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Full Term Pregnancy and delivery  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

(a) Means of injury \_\_\_\_\_

23. Signature L. M. Rordan (M. D. or other) \_\_\_\_\_  
L. P. Berg Date signed \_\_\_\_\_

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically

USE UNFADING BLACK INK—MAKE A PERMANENT RECORD  
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.

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

*Larry M. White*

Licensed Embalmer No.....

*3973*

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**