No. 2
1-10-39
17-39
X21492

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 37202

Registration District No. 7911

Primary Registration District No. 1003

Registrar's No. 9475

FILED DEC 11 1940

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis.
(If outside city or town limits, write "RURAL" and name of town)

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

(d) Length of stay: In hospital or institution One Week. (Specify whether in this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County

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

(d) Street No. 6205 North Point Ave. (If rural, give location)

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

3. (a) PRINT FULL NAME James J. Sheehan.

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Elizabeth Sheehan.

6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased JAN. (Month) 13, (Day) 1876 (Year)

8. AGE: Years 64 Months 10 Days 3 If less than one day hr. min.

9. Birthplace St. Louis, Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Insurance.

11. Industry or business

FATHER
12. Name Robert Sheehan.
13. Birthplace Ireland. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mary Maher.
15. Birthplace Ireland. (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Elizabeth Sheehan.
(b) Address 6205 North Point Ave.

17. (a) Burial. (Burial, cremation, or removal) (b) Date thereof 11-20-1940 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Arthur J. Donnelly
(b) Address 3840 Lindell Blvd

19. (a) NOV 19 1940 (Date received local registrar) (b) J. F. Bischoch (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 16th. year 1940 hour 3. minute 00 P. M.

21. I hereby certify that I attended the deceased from Feb. 1, 1940, 19__, to Nov. 16, 1940, 19__; that I last saw him alive on Nov. 16, 1940, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death Auricullar fibrillation; uremia.

Due to Chronic myocarditis
Chronic glomerulo-nephritis

Due to

Other conditions ----
(Include pregnancy within 3 months of death)

Major findings:
Of operations ----

Of autopsy ----

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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? ---- (Specify type of place)
While at work? (e) Means of injury

23. Signature Anthony V. Benincasa (M. D. or other) MD
Address 3621 N. 20th. Date signed 11/17/40

(Licensed Embalmer's Statement on Reverse Side)

3421. N. 20 St
9-10 am Sunday
9-10 " 7-8

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 Stanley Marshall

Licensed Embalmer No. 2868

P. O. Address 3840 Lindell

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

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