

Dr. SEP 11 1943  
Registration District No. **42**

Primary Registration District No. **1000**

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

1. PLACE OF DEATH:

(a) County **Atchison**

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

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

(d) Length of stay: In hospital or institution **Nine days**  
(Specify whether years, months or days)

In this community **Nine days**

3. (a) PRINT FULL NAME **Robert G. 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 **single**

6. (b) Name of husband or wife

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

7. Birth date of deceased **Oct. 13 20 1880 1876**  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<b>62</b>	<b>10</b>	<b>7</b>	hr. min.
<del>66</del>	<del>10</del>	<del>7</del>	

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

10. Usual occupation **paper hanger**

11. Industry or business **n**

MOTHER FATHER {

12. Name **Paterick Sneeihan**

13. Birthplace **Fermoy Ireland**  
(City, town, or county) (State or foreign country)

14. Maiden name **Julia Grogan**

15. Birthplace **Caledonia New York**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Sadie Sheehan**

(b) Address **Atchison, Kansas**

17. (a) **removal**  
(Burial, cremation, or removal)

(b) Date thereof **8/20/43**  
(Month) (Day) (Year)

(c) Place: burial or cremation **Atchison, Kansas**

18. (a) Signature of funeral director **Heaton Belside & Rowman**

(b) Address **319 So 10th**

19. (a) **8/20/43**  
(Date received local registrar)

(b) **Rose Helgoy**  
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Kansas** (b) County **Atchison**

(c) City or town **Atchison**  
(If outside city or town limits, write "RURAL")

(d) Street No. **317 N. 4th**  
(If rural, give location)

(e) Citizen of foreign country? **no** (Yes or No)  
If yes, name country **2**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **20**  
year **1943** hour **2** minute **55** A. M.

21. I hereby certify that I attended the deceased from **8/11/43** to **8/19/43** 19 **40**  
that I last saw him **live** alive on **8/19/43** 19 **40**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Septicemia**  
**Pericardial Abscess.**

Due to **Septicemia**

Due to **Pericardial Abscess.**

Other conditions **240**  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations **240**

Of autopsy

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? \_\_\_\_\_

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

(e) Means of injury \_\_\_\_\_

23. Signature **Dr. Greenberg** (M. D. or other)  
Address **P. 5000 St. Joseph** Date signed **8/20/43**

**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 *Frank A. Brown*  
Licensed Embalmer No. *1710*  
P. O. Address *St. Joseph, Mo.*

**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, fact should be so stated above.**