

D OCT 13 1943 18

Registration District No. _____

Primary Registration District No. **1003**

Registrar's No. **8666**

1. PLACE OF DEATH:

(a) County _____
 (b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: BARNES HOSPITAL
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Pike
 (c) City or town El Dara
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME MICHAEL SHANAHAN

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 Jessie Shanahan 6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased November 2 1871
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>71</u>	<u>10</u>	<u>27</u>	_____ hr. _____ min.

9. Birthplace El Dara Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Farming

12. Name Michael Shanahan Sr.

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

14. Maiden name Unavailable

15. Birthplace Unavailable Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Jessie Shanahan

(b) Address El Dara, Illinois

17. (a) Removal (b) Date thereof 9/30/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pittsfield, Illinois

18. (a) Signature of funeral director Albert H. Hoppe, Inc

(b) Address 4700 Washington Blvd

19. (a) SEP 30 1943 (b) J. F. Bredich
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPT. day 29
 year 1943 hour 7 minute 45 A.M.

21. I hereby certify that I attended the deceased from SEPT. 16 1943 to SEPT. 29 1943.
 that I last saw him alive on SEPT. 29 1943
 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis
 Duration _____

Due to 94
 Due to _____

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

Major findings: tatectomy, transurethral. Allergic asthma
 Operations _____

Of autopsy Benign Hypertrophy of prostate, acute cystitis, pyelitis
 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 M. C. Arney (M. D. or owner)
 Address BARNES HOSPITAL Date signed 9/30/43

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

MOTHER FATHER

000
117
9

999
R/O

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.....

.....
working under my personal supervision.

Registered Apprentice No.....

Signed..... *John G. Gonski*

Licensed Embalmer No..... *3398*

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, fact should be so stated above.