

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31266**

FILED SEP 24 1943

Registration District No. **22**

Primary Registration District No. **000**

Registrar's No. **1035**

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

1. PLACE OF DEATH:

(a) County **Missouri Buchanan**

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

(c) Name of hospital or institution:
420 South 15th Street /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **55 Years** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Micheal T. Shea**

3. (b) If veteran, name war **no**

3. (c) Social Security No. **no**

4. Sex **Male**

5. Color or race **White**

6. (a) Single, widowed, married, divorced, widowed **2 divorced Widowed**

6. (b) Name of husband or wife **Ellen Shea**

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

7. Birth date of deceased **July 19 1863**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
80	1	28	hr. min.

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

10. Usual occupation **Retired Larabee Mills**

11. Industry or business

MOTHER FATHER { 12. Name **Timothy Shea**

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

14. Maiden name **Ellen Polley**

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

16. (a) Informant **Mrs Ernest J. Wolfing**

(b) Address **2605 S. 15th St. Joseph, Mo**

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

(b) Date thereof **Sept. 20 43**
(Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Olivet Cemete**

18. (a) Signature of funeral director **Norman M. Sabin**

(b) Address **1802 Union St. Joseph, Mo.**

19. (a) **9/20/43** (Date received local registrar)

(b) **Rose** (Registrar signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Buchanan**

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

(d) Street No. **420 South 15th**
(If rural, give location)

(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **17**
year **1943** hour **9** minute **30 P. M.**

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

Immediate cause of death **arteria hileroni**

Due to **Age**

Due to

Other conditions (Include pregnancy within 3 months of death) **97**

Major findings: Of operations

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 **Herold Beck** (M. D. or other)

Address **King Hill, Mo.** Date signed **9/18/43**

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 John G. Hurley
Licensed Embalmer No. 9056
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.