

FILED SEP 30 1948

Registration District No.

Primary Registration District No.

1003

1. PLACE OF DEATH:

(a) County.....
(b) City or town St. Louis, Mo Ave
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3146 Portis Ave
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... 1 (Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME Elizabeth O. Shea

3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced, widowed

6. (b) Name of husband or wife..... Timothy 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased..... June UNKNOWN 1864
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
80 hr. min.

9. Birthplace..... Ireland 4
(City, town, or county) (State or foreign country)

10. Usual occupation..... Housework

11. Industry or business..... At Home

12. Name..... Unknown Sheehan 4

13. Birthplace..... Ireland 4
(City, town, or county) (State or foreign country)

14. Maiden name..... Unknown

15. Birthplace..... Ireland 4
(City, town, or county) (State or foreign country)

16. (a) Informant..... Mrs Marie Johann

(b) Address..... 3146 Portis Ave

17. (a) Burial (b) Date thereof..... Sept 20 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... Calvary Cemetery

18. (a) Signature of funeral director..... Kriegshauser

(b) Address..... 4228 So. Kingshighway

19. (a) SEP 19 1944 (b) J. Fredrick
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County..... MO
(c) City or town..... St. Louis (If outside city or town limits, write "RURAL") 9
(d) Street No..... 3146 Portis Ave (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country..... 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 17
year 1944 hour 3:20 minute 0 M.

21. I hereby certify that I attended the deceased from Oct 1943
Sept 1942 to Sept 17 1944
that I last saw him alive on 9-16-44 and that death occurred on the date and hour stated above.

Immediate cause of death.....
Arterio-sclerosis
Cerebral thrombosis

Due to.....

Due to.....

Other conditions..... Similarity of 2
(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?

While at work?..... (Specify type of place) (e) Means of injury..... 0

23. Signature..... A. F. Peag (M. D. or other)
Address..... 3150 Morganfield Rd Date signed..... 9/17/44

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

MOTHER FATHER

Dr. Gray

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

Edwin M. Permitt

Licensed Embalmer No. *3024*

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.