V. S. No. 2
100M—2-43
Rev. 5-17-39
X35697

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

31826

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 0

FILED SEP 18 1944

Registration District No. 3047 Primary Registration District No. 3069 Registrar's No. 1894

1. PLACE OF DEATH:

(a) County ST LOUIS

(b) City or town RICHMOND HTS MO (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: ST MARYS HOSP (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 HRS (Specify whether

In this community 3 HRS years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) ~~County~~ ST LOUIS

(c) City or town — (If outside city or town limits, write "RURAL") 000

(d) Street No. 4208 RUSSEL BLDY (If rural, give location) 17

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country 1

3. (a) PRINT FULL NAME MARY PATRICIA SHEA

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex FEMALE

5. Color or race W

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

6. (b) Name of ~~husband or wife~~ FATHER + MOTHER JOHN + MARION SHEA

6. (c) Age of ~~husband or wife~~ FATHER + MOTHER alive 25 years

7. Birth date of deceased SEPT (Month) 12 (Day) 1944 (Year)

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

9. Birthplace RICHMOND HTS MO (City, town, or county) U (State or foreign country)

10. Usual occupation —

11. Industry or business —

FATHER
12. Name JOHN SHEA
13. Birthplace GREEN BAY (City, town, or county) WIS (State or foreign country)

MOTHER
14. Maiden name MARION JANE MARTYN
15. Birthplace MENOMONEE (City, town, or county) MICH (State or foreign country)

16. (a) Informant John Shea

(b) Address 4208 Russell Blvd

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEP (Month) 14 (Day) 1944 (Year)

(c) Place: burial or ~~cremation~~ CALVARY CEM

18. (a) Signature of funeral director Watson Bowling

(b) Address 6[illegible] Clayton Rd

19. (a) SEP 15 1944 (Date received local registrar) (b) E. G. McGarvey M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 12 year 44 hour minute M.

21. I hereby certify that I attended the deceased from 3 hrs old, 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Prematurity	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

159

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 0

23. Signature Grey Jones (M. D. or other) M.D.

Address Lister Bldg Date signed 9-14-44

707 (Licensed Embalmer's Statement on Reverse Side)

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

Not embalmed, Registered Apprentice No.

working under my personal supervision.

Signed

Licensed Embalmer No.

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.