V. S. No. 2
50M—5-42
Rev. 5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Dr. Calloway

State File No. 34281

FILED NOV 6 1944

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 840

1. PLACE OF DEATH:

(a) County: GREENE

(b) City or town: Springfield (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1508 N. Clay (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 1 (Specify whether years, months or days)

In this community: 50 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Greene 29

(c) City or town: Springfield (If outside city or town limits, write "RURAL") 2 6

(d) Street No.: 1508 N. Clay (If rural, give location)

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

If yes, name country:

3. (a) PRINT FULL NAME: Mayme Sheeran

3. (b) If veteran, name war: No

3. (c) Social Security No. 488-16-0330

4. Sex: Female

5. Color or race: White

6. (a) Single, widowed, married, divorced: Single 0

6. (b) Name of husband or wife: None

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

7. Birth date of deceased: Dec. (Month) 25 (Day) 1864 (Year)

8. AGE: Years 79 Months 9 Days 27 If less than one day hr. min.

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

10. Usual occupation: Home

11. Industry or business:

FATHER 12. Name: Patrick W. Sheeran

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

MOTHER 14. Maiden name: Elizabeth McDonough

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

16. (a) Informant: Mrs. B.C. Burtt

(b) Address: Springfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10/25/44 (Month) (Day) (Year)

(c) Place: burial or cremation: St. Mary

18. (a) Signature of funeral director: H.H. Lohmeyer

(b) Address: Springfield, Mo.

19. (a) 10-25-44 (Date received local registrar) (b) Dr. N.S. Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 22 year 1944 hour 5:00 minute a. M.

21. I hereby certify that I attended the deceased from Fall 1943, 19..., to 10/22, 1944, that I last saw her alive on 10/18, 1944, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Uremia	6d.
Due to: Cardio-vascular-renal disease	1yr
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
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? (Specify type of place)

While at work? (e) Means of injury:

23. Signature: Guy D. Calloway (M. D. or other) MD

Address: Springfield, Mo Date signed: 10/23/44

(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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed.....

Licensed Embalmer No. 2457

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.