

FILED JAN 13 1945

Registration District No. **23**

Primary Registration District No. **3048**

Registrar's No. **206-**

1. PLACE OF DEATH:

(a) County **Madaway**
(b) City or town **Marionville**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **None**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **None!**
In this community **about 5-3 yrs.**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Mary Agnes Shea**
3. (b) If veteran, name war. _____ 3. (c) Social Security No. _____

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **SO**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **March - 10 - 1863**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	81	8	14	hr. _____ min.

9. Birthplace **St Joseph Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housekeeper**

11. Industry or business _____

12. Name **Gremiah Shea**
13. Birthplace **Unknown Ireland**
(City, town, or county) (State or foreign country)
14. Maiden name **Elizabeth Garrett**
15. Birthplace **Unknown Ireland**
(City, town, or county) (State or foreign country)

16. (a) Informant **Joseph Schragler**
(b) Address **Barnard Mo**
17. (a) **Burial** (b) Date thereof **12-27-44**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Conception of Mary**

18. (a) Signature of funeral director **Campbell Funeral Home**
(b) Address **Marionville Mo**
19. (a) **Dec 26 44** (b) **Cliff Barber**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Madaway 74**
(c) City or town **Marionville 1**
(If outside city or town limits, write "RURAL") **2**
(d) Street No. **South Davis**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **24**
year **1944** hour **7** minute **30 P.M.**
21. I hereby certify that I attended the deceased from **12-15**, 19**44**, to **12-24**, 19**44**;
that I last saw h. **lv.** alive on **12-24**, 19**44**;
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral hemorrhage**
myocarditis
Due to **Arterio sclerosis**

Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations **92e**
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) (a) Means of injury _____
23. Signature **J. M. Boyle** (M. D. registrar)
Address **Marionville Mo** Date signed **12-26-44**

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

74
1
2

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..... *W. H. Campbell*

Licensed Embalmer No. *2630*

P. O. Address..... *Maryville 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.