

7. S. No. 2  
FORM-5-43  
Rev. 5-17-39  
I X36671

FILED FEB 7 1945

State File No. \_\_\_\_\_

Registration District No. **318**

Primary Registration District No. **1000**

Registrar's No. **77A**

1. PLACE OF DEATH:

(a) County \_\_\_\_\_

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

(c) Name of hospital or institution:  
City Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 Weeks  
(Specify whether \_\_\_\_\_)

In this community 70 Years  
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County \_\_\_\_\_

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

(d) Street No. 1109 N. 12th ST.  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Della M. Shea

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Edward Shea

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

7. Birth date of deceased Aug. 6 1873  
(Month) (Day) (Year)

8. AGE: Years 71 Months 2 Days 17  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Dont Know Ohio  
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business \_\_\_\_\_

12. Name William French

13. Birthplace Dont Know  
(City, town, or county) (State or foreign country)

14. Maiden name Dont Know

15. Birthplace Dont Know  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Cora Sullivan

(b) Address 1436 N. 16 th St.

17. (a) Burial (b) Date thereof 1-27-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Arthur J. Durnelly

(b) Address 3840 Grand Blvd

19. (a) JAN 25 1945 (b) J. F. Brebeck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 23, year 1945 hour 7 minute A. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Fractured left hip  
Anterior-superior surface when  
deceased fell to the floor at her  
home 1109 N. 12th St. in garage  
time unknown

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence Jan 9 1945

(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? Home

While at work? \_\_\_\_\_ (Specify type of place)

23. Signature Arthur J. Durnelly (M. D. or other) \_\_\_\_\_  
Address 3840 Grand Blvd Date signed 1/24/45

PHYSICIAN  
Underline the cause to which death should be charged statistically.

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

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**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. VanMatre

Licensed Embalmer No. 2825

P. O. Address 4340 Lafayette

**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.**