

S. No. 2  
DM-5-43  
V. 5-17-39  
I X36671

MAILED MAY 12 1945

318 Primary Registration District No. 1003

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1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:  
5094 Cabanne  
(If not in hospital or institution, write street number or location)

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

In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME Vincent McShane

3. (b) If veteran, name war No

3. (c) Social Security No. None

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

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

7. Birth date of deceased December 8, 1861  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>83</u>	<u>4</u>	<u>21</u>	hr. min.

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

10. Usual occupation Lawyer

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

12. Name Michael McShane

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

14. Maiden name Catherine O'Regan

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

16. (a) Informant Miss Bird McShane

(b) Address 5094 Cabanne

17. (a) Burial (b) Date thereof 5 - 2 - 45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director John J. Stuart

(b) Address 1225 Union Bldg

19. (a) MAY 1 1945 (b) J. J. Brueck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 006

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL") 912

(d) Street No. 5094 Cabanne Ave.  
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 29th  
year 1945 hour 3:30 minute \_\_\_\_\_ P.M.

21. I hereby certify that I attended the deceased from Jan 1 1945 to Apr 29 1945  
that I last saw him alive on Apr 28 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Alcoholism Duration 27mo

Due to Hypertension, arteries sclerosis 10 yrs

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

Other conditions 83  
(Include pregnancy within 3 months of death)

Major findings: none PHYSICIAN \_\_\_\_\_

Of operations: none

Of autopsy: none

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) no

(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 \_\_\_\_\_

23. Signature Mrs. J. Lanpan (M. D. or other) JO

Address 5803 Plymouth Ave Date signed 5/30/45

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

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17  
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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 B. W. Wilkinson  
Licensed Embalmer No. 3575  
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.**