. S. No. 2
M—8-43
v. 5-17-39
I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35854

Registration District No. 318 FILED DEC 7 1945

Primary Registration District No. 1003

Registrar's No. 10296

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

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution: Faith Hospital
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

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

(d) Street No. 4949 Lotus ave.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME MARY SHERAN

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 Widow

6. (b) Name of husband or wife Thos F. Sheran

6. (c) Age of husband or wife if alive Dec'd years

7. Birth date of deceased Feb 16 1866
(Month) (Day) (Year)

8. AGE: Years 79 Months 9 Days 11 If less than one day hr. min.

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

10. Usual occupation Housekeeper

11. Industry or business

FATHER
12. Name Thos. Lahert
13. Birthplace Ireland (City, town, or county) 4 (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Ireland (City, town, or county) 4 (State or foreign country)

16. (a) Informant Mrs Kate Hughes
(b) Address 4949 Lotus ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/29/45 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary. Sullivan Bro's

18. (a) Signature of funeral director 2849 N. Euclid ave.
(b) Address

19. (a) NOV 28 1945 (Date received local registrar) F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 27th year 1945 hour 7 minute P. M.

21. I hereby certify that I attended the deceased from Oct. 2 - 1945 to Nov. 27, 1945, to , 19 ; that I last saw her alive on Nov. 26 1945, 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failure due to chronic myocarditis auricular fibrillation - and

Due to decompensation of myocardium - chronic nephritis

Due to Terminal pneumonia senilitis

Other conditions Cancer - arteriosclerosis
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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) no

(b) Date of occurrence

(c) Where did injury occur? no (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? no (Specify type of place)

While at work? no (e) Means of injury

23. Signature J. P. Murphy (M. D. or other)

Address 2616 No. Kingshighway St Louis Mo Date signed 11/28/45

(Licensed Embalmer's Statement on Reverse Side)

Faith Hospital
Dr. Murphy. 90-8770
7616 No Kingshighway

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 Robert L Brinkman

Licensed Embalmer No. 3553

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.