

S. No. 2
M-8-43
5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 2 1946
STANDARD CERTIFICATE OF DEATH

State File No. **12744**
Registrar's No. **13**

Registration District No. **104** Primary Registration District No. **4176**

1. PLACE OF DEATH:
(a) County **Dunklin**
(b) City or town **Malden**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
104 S. Taylor /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **none**
(Specify whether
In this community **36 yrs.**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Dunklin 35**
(c) City or town **Malden 3**
(If outside city or town limits, write "RURAL")
(d) Street No. **104 S. Taylor 1**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME **Margaret Jane Sheehy**
3. (b) If veteran, name war **no**
3. (c) Social Security No. **no**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **April** day **5**
year **1946** hour **8** minute **45 AM.**

4. Sex **female** 5. Color or race **white**
6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Charles A. Sheehy**
6. (c) Age of husband or wife if alive **73** years
7. Birth date of deceased **January 1874**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **April 5 1946** to **April 5 1946**
that I last saw her alive on **April 5 1946**
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
72 2 29 -- hr. -- min.

Immediate cause of death **Cerebral Hemorrhage. 4 hours**
Due to **Age and Arterial Sclerosis**

9. Birthplace **Henderickson Mo. 0**
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations **30**
Of autopsy

10. Usual occupation **Housewife**
none

11. Industry or business
12. Name **Doc. Ausborne**
13. Birthplace **Henderickson Mo. 0**
(City, town, or county) (State or foreign country)
14. Maiden name **Deliah Daniels**
15. Birthplace **Faredealing Mo. 0**
(City, town, or county) (State or foreign country)

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

16. (a) Informant **Charles A. Sheehy**
(b) Address **Malden, Mo.**

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?

17. (a) **Burial** (b) Date thereof **4-7-46**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Malden Memorial C.**

18. (a) Signature of funeral director **Day Funeral Home**
(b) Address **Malden, Mo.**

While at work? (Specify type of place) **2**
(e) Means of injury
23. Signature **J. Carlstrom** M. D. or other
Address **malden** Date signed **4/30/46**

19. (a) **4-22-46** (b) **J. S. Schuman**
(Date received local registrar) (Registrar's signature)

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

11649

RECEIVED
District Health Offloe No. 2,
District File Number 546-556
Date Filed 5-1-46

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 J. W. Schuman
Licensed Embalmer No. 4086
P. O. Address Malden, 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.