

No. 2
12-45
17-39
X47070

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 37184

FILED NOV 17 1947

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 1335

1. PLACE OF DEATH:

(a) County Quebranon

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

(c) Name of hospital or institution: State Hospital #2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 wks 11 mos 1 day
(Specify whether)

In this community Lifetime
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Quebranon

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

(d) Street No. 24 1/2 35 1/2 11th Street
(If rural, give location)

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

If yes, name country None

3. (a) PRINT FULL NAME Nellie Sheehan

3. (b) If veteran, name war No

3. (c) Social Security No. Nil

4. Sex Female 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 alive _____ years

7. Birth date of deceased Nov 28 1884
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 7 year 1947 hour 3 minute 50 P M.

21. I hereby certify that I attended the deceased from Jan 1st, 1947 to 11-7, 1947

What I last saw her alive on 11-7, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial infarction

Due to arteriosclerosis 8 years

Due to None

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

Major findings: Of operations _____

Of autopsy None

Duration 2 days

8. AGE:	Years	Months	Days	If less than one day
<input checked="" type="checkbox"/>	<u>62</u>	<u>11</u>	<u>9</u>	hr. min.

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

10. Usual occupation None

MOTHER FATHER

11. Industry or business _____

12. Name Mike Sheehan

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

14. Maiden name Margaret Foley

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

16. (a) Informant Mike Sheehan

(b) Address 2322 1/2 St. Joseph Mo

17. (a) Witness (b) Date thereof Nov 8 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kirksville, Missouri

18. (a) Signature of funeral director Thomas W. Sinden

(b) Address 1802 Union St. St. Joseph Mo.

19. (a) 11-12-47 (b) G. C. Jenkins
(Date received local registrar) (Registrar's signature)

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)

(e) Means of injury 0

23. Signature G. C. Jenkins (M. D. or other) _____

Address State Hospital #2 Date signed 11/7/1947

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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.....

Gray F. Hayes, Jr
working under my personal supervision.

Registered Apprentice No. *88*

Signed *Robert H. Yapple*

Licensed Embalmer No. *3308*

P. O. Address *St Joseph, 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.