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

#89566

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED SEP 20 1948

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31428

Registration District No. 318 Primary Registration District No. 1008 Registrar's No. 7993

1. PLACE OF DEATH:

(a) County St. Louis, Mo.

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

(c) Name of hospital or institution: St. Louis City Hospital-Max C. Starkloff Memorial (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 0 (Specify whether years, months or days) In this community

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. 4705 Thrush Ave. (If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME META SHAUGHNESSY

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 widowed

6. (b) Name of husband or wife John Shaughnessy

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

7. Birth date of deceased Dec. (Month) 19 (Day) 1865 (Year)

8. AGE: Years 82 Months 8 Days 21 If less than one day hr. min.

9. Birthplace Hamburg (City, town, or county) Germany (State or foreign country)

10. Usual occupation Home

11. Industry or business

MOTHER FATHER

12. Name John Hatchman

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

14. Maiden name Meta Thea

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

16. (a) Informant Antoinette Wadsworth

(b) Address 4705 Thrush Ave.

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 9-13-48 (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Drehmann-Harral

(b) Address 1905 Union Blvd.

19. (a) SEP 13 1948 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 10th year 1948 hour 6 minute 30 P M.

21. I hereby certify that I attended the deceased from 9/2/48, 19, to Sept. 10th, 1948, that I last saw her alive on Sept. 10th, 1948 and that death occurred on the date and hour stated above.

Immediate cause of death: Myocardial Infarction

Due to: Arteriosclerotic Heart Disease

Due to:

Other conditions (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)

(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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Geo. L. Ryan M.D. (M.D. preferred)

Address 1515 Lafayette Date signed 9/11/48

(Licensed Embalmer's Statement on Reverse Side)

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 Albert R. Thompson

Licensed Embalmer No. 4237

P. O. Address St. Louis

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.