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FILED AUG 29 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26187

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 923

1. PLACE OF DEATH a. COUNTY Buchanan			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Buchanan		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph, Mo.		c. LENGTH OF STAY (in this place) 6 Mos.	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph, Mo.		3
d. FULL NAME OF HOSPITAL OR INSTITUTION 701 South 17th Str.			d. STREET ADDRESS (If rural, give location) 2117 Faraon Street		

3. NAME OF DECEASED a. (First) Mary b. (Middle) A c. (Last) Sheridan			4. DATE OF DEATH (Month) (Day) (Year) Aug. 19 1949		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Sept. 28, 1863		9. AGE (In years last birthday) 85	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HRS. Hours	IF UNDER 1 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Atchison Kansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
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13a. FATHER'S NAME Unk. Colgan		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Andrew	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mr Philip Sheridan 2117 Faraon St.			
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Heart Disease Arterio-sclerosis					5 1/2
ANTECEDENT CAUSES	DUE TO (b) Arterio-sclerosis general					
	DUE TO (c) Senility					
II. OTHER SIGNIFICANT CONDITIONS	Conditions contributing to the death but not related to the disease or condition causing death.					41500

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from Jan 1, 1940, to Aug 20, 1949, that I last saw the deceased alive on Aug 19, 1949, and that death occurred at 9:15 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) John J. Byrne M.D.		23b. ADDRESS St. Joseph Mo		23c. DATE SIGNED Aug 20, 49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8/22/1949	24c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	24d. LOCATION (City, town, or county) (State) St. Joseph, Mo.	
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DATE REC'D BY LOCAL REG. Aug 25, 1949	REGISTRAR'S SIGNATURE 382 E. E. Jenkins		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Norman W. (Hiden) 1802 Union St. St. Joseph Mo.	
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Robert H. Maple

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.