

FILED DEC 13 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Dr. Glenn 36983

State File No.

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 5465 Registrar's No. 1061

4-0747

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

| | | | |
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| 1. PLACE OF DEATH a. COUNTY <u>Greene</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u> | |
| b. CITY (If outside corporate limits, write RURAL and give town) <u>Springfield</u> OR <u>Rural N. Campbell Twshp</u> | | c. CITY (If outside corporate limits, write RURAL and give township) <u>Springfield</u> OR <u>Rural N. Campbell Twshp</u> | |
| c. LENGTH OF STAY (In this place) _____ | | d. STREET ADDRESS (If rural, give location) <u>Route # 10</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Route # 10</u> | | | |

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|-------------------------------------|----------------------------|-------------------|-------------------------|--|
| 3. NAME OF DECEASED (Type or Print) | a. (First) <u>Winifred</u> | b. (Middle) _____ | c. (Last) <u>Sheedy</u> | 4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 2, 1949</u> |
|-------------------------------------|----------------------------|-------------------|-------------------------|--|

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|----------------------|-------------------------------|---|---------------------------------|---|---|---|
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>unknown</u> | 9. AGE (In years last birthday) <u>61</u> | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HRS. Hours _____ Min. _____ |
|----------------------|-------------------------------|---|---------------------------------|---|---|---|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | 11. BIRTHPLACE (State or foreign country) <u>Springfield, Mo.</u> | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> |
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| 13a. FATHER'S NAME <u>John Carroll</u> | 13b. MOTHER'S MAIDEN NAME <u>Elizabeth ?</u> | 14. NAME OF HUSBAND OR WIFE <u>Mike Sheedy</u> |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | 16. SOCIAL SECURITY NO. <u>No</u> | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mike Sheedy Rt # 10 Spfld, Mo.</u> |
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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, ashenia, etc. It means the disease, injury, or complication which caused death. | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerotic Heart Disease</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u> | | |
| | DUE TO (c) _____ | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |

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| 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) _____ | 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 2-4-1949 to 11-17-1949, that I last saw the deceased alive on 11-17-1949, and that death occurred at 11 a m., from the causes and on the date stated above.

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|---|-------------------------------------|---------------------------------|
| 23a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M.D.</u> | 23b. ADDRESS <u>Springfield Mo.</u> | 23c. DATE SIGNED <u>12/2/49</u> |
|---|-------------------------------------|---------------------------------|

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|---|--------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>12/5/49</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>St. Mary</u> | 24d. LOCATION (City, town, or county) (State) <u>Springfield, Mo.</u> |
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| DATE REC'D BY LOCAL REG. <u>12-3-49</u> | REGISTRAR'S SIGNATURE <u>[Signature]</u> | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>H.H. Lohmeyer Springfield, Mo.</u> |
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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.

Signed Walter E. Hensel.....

Signed.....
Student Embalmer

Licensed Embalmer No. 3808

P. O. Address Springfield 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.