

FILED JAN 17 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3413

STATE FILE NUMBER

232

Registration District No. _____

318

Primary Registration District No. _____

1003

Registrar's No. _____

300
-57

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hospital		Length of stay in 1b	d. STREET ADDRESS 1208a Tamm		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First John Middle T Last O'Shea			4. DATE OF DEATH Month Jan Day 6 Year 1958		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 1, 1895	9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) vending business		10b. KIND OF BUSINESS OR INDUSTRY cigarettes	11. BIRTHPLACE (City and state or country) Ireland	12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Thomas O'Shea		13b. MOTHER'S MAIDEN NAME not known		14. NAME OF HUSBAND OR WIFE Daisy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	17. INFORMANT Address Daisy O'Shea 1208a Tamm		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized abdominal carcinoma					INTERVAL BETWEEN ONSET AND DEATH 3 yrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 199.2					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION		COUNTY STATE
21. I attended the deceased from 1-15-56 to 1-6-58 and last saw her alive on 1-6-58 Death occurred at 7:50 P m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE S. H. Bowden M.D. (Degree or title)		22b. ADDRESS 6347 Grand		22c. DATE SIGNED 1-8-57	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 1/10/1958	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
24. FUNERAL DIRECTOR J L Ziegenhein & Sons 7027 Gravois		25. DATE RECD. BY LOCAL REG. JAN 9 '58		26. REGISTRAR'S SIGNATURE Carl Smith M.D. m 86.	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, County, etc. must use only standard nomenclature in Part 18. All diseases in Part I must be causally related.

Jan 6 1959

MAY 20 1959
VS

1088

1088

Office

I

John

April 1, 1959

A

White

Interment

Interment

Interment

Interment

Interment

Interment

Interment

Interment

Interment

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
Signature of Student Embalmer

Signed *B. P. Kidwell*

Licensed Embalmer No. 3877
P. O. Address 7027 Graves

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting:
If this body is not embalmed, fact should be so stated above.