

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-036614  
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4646

FILED OCT 23 1958

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>JACKSON</u>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>JACKSON</u> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <u>KANSAS CITY</u>            |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   | c. CITY OR TOWN <u>KANSAS CITY</u><br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                       |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>328 So Lawrence</u> |  | Length of stay in lb<br><u>43 Yrs</u>  | d. STREET ADDRESS (If outside, give location)<br><u>328 So Lawrence</u><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

|   |                                  |   |   |  |   |
|---|----------------------------------|---|---|--|---|
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>SARAH</u> Middle <u>A</u> Last <u>Shea</u>                   |                                  |   | 4. DATE OF DEATH<br>Month <u>Sept</u> Day <u>30</u> Year <u>1958</u>  |  |   |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>August 4, 1877</u>                             | 9. AGE (In years last birthday)<br><u>81</u> | IF UNDER 1 YEAR<br>Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u> |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (City and state or country)<br><u>Kearney Missouri</u> |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                 |

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 13a. FATHER'S NAME<br><u>Horace Combs</u>   |  | 13b. MOTHER'S MAIDEN NAME<br><u>UNKNOWN</u> |  | 14. NAME OF HUSBAND OR WIFE<br><u>Daniel T Shea (Dec)</u>          |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><u>NO</u> |  | 16. SOCIAL SECURITY NO.<br><u>None</u>      |  | 17. INFORMANT<br>Address<br><u>Rea Shea 6233 E 11th St K.C. Mo</u> |  |

|  |  |  |   |
|--|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary artery thrombosis</u> |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 hrs</u>  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <u>Generalized arteriosclerosis</u>                       |  |  |   |
| DUE TO (c) <u>Hypertension</u>   |  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><u>H2O1</u>                   |  |  | 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour <u>    </u> Month, Day, Year<br>a.m. <u>    </u> p.m. <u>    </u>             |  |  |  |  |  |

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 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 <u>Aug 5 - 1958</u> and last saw <sup>her</sup> <sub>him</sub> alive on <u>Sept 19 - 1958</u><br>Death occurred at <u>    </u> on the date stated above; and to the best of my knowledge from the causes stated. |  |  |  |   |  |

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 22a. SIGNATURE<br><u>R. D. Dwyer</u> (Degree or title) <u>MD</u> |  | 22b. ADDRESS<br><u>1886 Swift Dr. North End Ct. Mo</u>      |  | 22c. DATE SIGNED<br><u>10/2/58</u>                               |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>       |  | 23b. DATE<br><u>10-4-1958</u>                               |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>St. Mary's Cemetery</u> |  |
|  |  | 23d. LOCATION (City, town, or county)<br><u>KANSAS CITY</u> |  | (State)<br><u>MO</u>   |  |

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 24. FUNERAL DIRECTOR<br><u>Sheil Funeral Home K.C. MO</u> |  | 25. DATE RECD. BY LOCAL REG.<br><u>10-2-58</u> |  | 26. REGISTRAR'S SIGNATURE<br><u>Reva Minshall</u> |  |
|---|--|--|--|---|--|

All diseases in Part I must be causally related. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

R. D. Dwyer



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 Richard E. Carroll.

Licensed Embalmer No. 4829

P. O. Address KCSmo

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.