

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011387

STATE FILE NUMBER

21653

Health,
Welfare
Public
Service

300
-57

REGISTRATION DISTRICT No. _____ PRIMARY REGISTRATION DISTRICT No. _____ REGISTRATION No. _____

1. PLACE OF DEATH
a. COUNTY _____
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Inside Limits Yes No
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hosp. Length of stay in lb _____

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY St. Louis
c. CITY OR TOWN Clayton 4442 Inside Limits Yes No
d. STREET ADDRESS (If outside, give location) #9 Brighton Way Reside on Farm Yes No

3. NAME OF DECEASED First JOHN Middle J. Last SHEA
4. DATE OF DEATH Month Feb. Day 14 Year 1959

5. SEX Male 6. COLOR OR RACE White 7. MARRIED NEVER MARRIED WIDOWED DIVORCED 8. DATE OF BIRTH June 24, 1871 9. AGE (In years last birthday) 87 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) Executive-Missouri 10b. KIND OF BUSINESS OR INDUSTRY Peerless Co. 11. BIRTHPLACE (City and state or country) Ireland 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Unknown Shea 13b. MOTHER'S MAIDEN NAME Unknown Buckley 14. NAME OF HUSBAND OR WIFE Late Mary G. Shea

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give number or dates of service) No 16. SOCIAL SECURITY NO. None 17. INFORMANT Joseph A. Shea #30 Orchard Lane Address Kirkwood, Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia
DUE TO (b) Ruptured Aortic Aneurysm of Ascending
DUE TO (c) 572.1
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriosclerotic Heart Disease & Coronary Atherosclerosis

INTERVAL BETWEEN ONSET AND DEATH 1 day

19. WAS AUTOPSY PERFORMED? YES NO

20a. ACCIDENT SUICIDE HOMICIDE 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 _____ p.m. _____

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.) _____ 20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____

21. I attended the deceased from 2-14-59 and last saw him alive on 2-13-59
Death occurred at 2:15 A. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Carl J. Shea, M.D. (Degree or title) 22b. ADDRESS 18 S Kings Highway 22c. DATE SIGNED 2-16-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment 23b. DATE Feb. 17, 1959 23c. NAME OF CEMETERY OR CREMATORY Calvary Mausoleum 23d. LOCATION (City, town, or county) (State) St. Louis, Mo.

24. FUNERAL DIRECTOR Kriegshauser ADDRESS 4228 S. Kings Highway 25. DATE RECD. BY LOCAL REG. FEB 16 '59 26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 *William B. White*

Licensed Embalmer No. *4391*

P. O. Address *220 S. 1st St. ...*

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.