

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

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FILED VS DEC 21 1959 317

500 590 Registrar's No 3339

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 590 Registrar's No 3339

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Rural Wellston		Length of stay in 1b 53 yrs. 3 mos.	c. CITY OR TOWN St. Louis, Missouri Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION St. Vincent's Hospital		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 7301 St. Charles Rock Rd. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First ALICE Middle SHEEHAN Last SHEEHAN			4. DATE OF DEATH Month December Day 12 Year 1959		
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5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2/23/82	9. AGE (last birthday) 77 yrs.	IF UNDER 1 YEAR Months 9 Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (City and state or country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME John Sheehan	13b. MOTHER'S MAIDEN NAME Alice O'Keefe	14. NAME OF HUSBAND OR WIFE none
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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) no	16. SOCIAL SECURITY NO. none	17. INFORMANT Address R cords of St. Vincent's Hospital
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Bronchial Asthma		Years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Generalized Arteriosclerosis	Years
	DUE TO (c) Pulmonary Fibrosis	Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic Schizophrenia - Yrs.	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <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
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21. I attended the deceased from Jan. 1, 1948 to Dec. 12, 1959 and last saw her alive on Dec. 12, 1959 Death occurred at 11:15 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE St. Baulet md (Degree or title)	22b. ADDRESS 7301 St. Charles Rock Rd.	22c. DATE SIGNED 12/12/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12/15/59	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Mo.
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24. FUNERAL DIRECTOR Cullen Kelly ADDRESS 7267 Natural Bridge	25. DATE RECD. BY LOCAL REG. 12-14-59	26. REGISTRAR'S SIGNATURE J. M. Murphy md
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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

James A. Lammert

Licensed Embalmer No. 4142

P. O. Address St. Louis

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.