

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-017329

FILED VS MAY 2 1960

MC-19 362 120

SL 8581

STATE FILE NUMBER

Registration District No.

Primary Registration District No.

Registrar's No.

2 4198

ENDED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>915 N. GRAND, ST. LOUIS, MO.</b>		Length of stay in 1b <b>8 days</b>		c. CITY OR TOWN <b>ST. LOUIS</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VET. ADM. HOSPITAL</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2330 HICKORY</b>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>F.</b> Last <b>SHEA</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>16</b> Year <b>1960</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>11/12/98</b>	9. AGE (last birthday) <b>61</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>POSTAL EMPLOYEE</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (City and state or country) <b>ST. LOUIS, MO.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>JOHN P. SHEA</b>			13b. MOTHER'S MAIDEN NAME <b>EMMA FRANK</b>			14. NAME OF HUSBAND OR WIFE -----	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WW-2</b>			16. SOCIAL SECURITY NO. -----	17. INFORMANT Address <b>Edward Shea, 2330 Hickory, St. Louis, Mo.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BULBAR PARALYSIS</b>							INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>ASPIRATION PNEUMONIA</b>							<b>1 WEEK</b>
DUE TO (c) <b>PARALYSIS AGITANS</b>							<b>350x</b> <b>2 YEARS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N- <input type="checkbox"/> Unknown		
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 a.m. p.m.	Month, Day, Year						
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
21. <b>VA</b> attended the deceased from <b>4/8/60</b> to <b>4/16/60</b> and last saw <b>him</b> alive on <b>4/16/60</b> Death occurred at <b>12:25 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>WELLS J. JACOBY</b> (Degree or title) <b>M.D.</b>				22b. ADDRESS <b>VAH, ST. LOUIS, MO.</b>			22c. DATE SIGNED <b>4/16/60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>4/19/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23d. LOCATION (City, town, or county) <b>St. Louis, Mo.</b>			(State)
24. FUNERAL DIRECTOR ADDRESS <b>McLaughlin's, 2301 Lafayette</b>				25. DATE RECD. BY LOCAL REG. <b>APR 18 1960</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>		

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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed James R. Chapman

Licensed Embalmer No. 45

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.