

AMENDED

Registration District No. 218 FILED AUG 14 1961

Primary Registration District No. 1003

Registrar's No. 7402

STATE FILE NUMBER

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Mo.</u>		Length of stay in lb over <u>29</u> years	c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis State Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4133 San Francisco</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELEANOR C. SHEAHAN</u>			4. DATE OF DEATH Month Day Year <u>August 8, 1961</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-22-02</u>	9. AGE (last birthday) <u>58 yrs.</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SECRETARY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BANK</u>	11. BIRTHPLACE (City and state or country) <u>ST. LOUIS MO</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Jermine Sheahan</u>		13b. MOTHER'S MAIDEN NAME <u>Nellie (Grograve)</u>		14. NAME OF HUSBAND OR WIFE <u>-</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT Address <u>MAE RIOR DAN 6017 COLUMBIA</u>		
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) <u>Perforation of sigmoid colon, with feco-purulent peritonitis</u>					
DUE TO (b) <u>Adenocarcinoma of rectum, with lymph node and liver metastases. (Fracture of Hip - fell at Hospital in Jan-1961)</u>					
DUE TO (c) <u>Hospital in Jan-1961</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Fibrous tuberculosis with cavitation, healed, apical, bilateral.</u>				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>904.7-45 HA</u>			
20c. TIME OF INJURY Hour a.m. p.m. <u>1-1961</u>	Month, Day, Year <u>7</u>				
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>13 Hospital</u>	20f. CITY, TOWN, OR LOCATION <u>St. Louis</u>	COUNTY <u>Mo.</u>	STATE	
21. I attended the deceased from <u>7-6-61</u> to <u>8-8-61</u> and last saw her alive on <u>8-8-61</u>			Death occurred at <u>L.N. McCullough, M.D.</u> <u>4:00</u> P.m. on the date stated above, and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <u>L.N. McCullough M.D.</u>		22b. ADDRESS <u>5400 Arsenal St.</u>	22c. DATE SIGNED <u>8-9-61</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>8-10-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO.</u>		
24. FUNERAL DIRECTOR <u>HOWARD A. MICHEL</u>		ADDRESS <u>5930 SOUTHWEST</u>	25. DATE RECD. BY LOCAL REG. <u>AUG 9 1961</u>	26. REGISTRAR'S SIGNATURE <u>Paul Smith M.D.</u>	

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

*Lustan W. Die*

Licensed Embalmer No. 4329

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.