

SEP 26 1930

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

27746

1. PLACE OF DEATH

County St. Francois

Registration District No. 773

File No. _____

Township 1 1 1

Primary Registration District No. 0018A

Registered No. 117

Near Farmington, Mo. (No. State Hosp No 4)

St. _____ Ward _____

2. FULL NAME Andy Shannon

(a) Residence. No. Farmington, Mo. St. _____ Ward _____

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

unknown

5A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND OF (OR) WIFE OF

Unknown

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

unknown

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

Unknown

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer

231 107

9. BIRTHPLACE (CITY OR TOWN)

Unknown

(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14. INFORMANT

Hospital Records.

(Address)

15. FILED

8-9-30

B. J. Robison
REGISTRAR

2

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

Aug 9 1930

17.

I HEREBY CERTIFY, That I attended deceased from Aug 6, 1930 to Aug 9, 1930 that I last saw him alive on Aug 8, 1930 and that death occurred, on the date stated above, at 2:20 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchial Pneumonia
can't say as to its duration
for I can only see from post
two days. (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

Suspected Pul. Tuberculosis (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) P. J. Fair, M. D.

89-1930 (Address) Hosp #4 Farmington Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

St. Francois County Cemetery

8/9 1930

20. UNDERTAKER

ADDRESS

Heider and Co

Farmington

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

