

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

Do not use this space.

24146

1. PLACE OF DEATH

County Barry Copper Creek Registration District No. 30
Township Pioneer Mo. Primary Registration District No. 3041
City Pioneer Mo. (No. _____) St. _____ Ward _____

2. FULL NAME

(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode) (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 Female 4. COLOR OR RACE Wh. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED (OR) WIFE OF William Shannon

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 30 1848

7. AGE YEARS 83 MONTHS 1 DAYS 25 If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as planner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tennessee

13. NAME A B Greer

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn

15. MAIDEN NAME Catherine Gregory

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn

17. INFORMANT (ADDRESS) Rachel Long

18. BURIAL, CREMATION, OR REMOVAL PLACE Blue Cemetery DATE July 26 1931

19. UNDERTAKER (ADDRESS) Belt & Mitchell

20. FILED _____ 19 _____ Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) _____, 19 _____

22. I HEREBY CERTIFY, That I attended deceased from July 1st, 1931, to July 25, 1931.
I last saw her alive on July 1, 1931. Death is said to have occurred on the date stated above, at 7 A. m.
The principal cause of death and related causes of importance were as follows:

Senility
169
Other contributory causes of importance: _____
Date of onset _____

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____

(Signed) J. Russell, M. D.

(Address) Farren Mo.

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.

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**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Warren Registration District No. 30
Township Capps Creek Primary Registration District No. 5041
City (No. _____) _____ St. _____ Ward _____

File No. _____
Registered No. _____

2. FULL NAME

Elizabeth Jane Shannon
(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode) (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 <u>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Wid</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>William Shannon</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>May 30 - 1848</u>		
7. AGE <u>83</u>	YEARS <u>1</u>	MONTHS <u>0</u>
DAYS <u>25</u>		IF LESS than 1 day, _____ hrs. or _____ min.
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>housewife</u>		
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.		
10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 23, 1931

22. I HEREBY CERTIFY, That I attended deceased from July 1st to July 25, 1931
I last saw him alive on July 1, 1931 Death is said to have occurred on the date stated above, at _____ m.
The principal cause of death and related causes of importance were as follows:
Senility
Date of onset _____

Other contributory causes of importance: _____

MOTHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Tennessee</u>
	13. NAME <u>B. Greer</u>
FATHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Tennessee</u>
	15. MAIDEN NAME <u>Catherine Gregory</u>
INFORMANT	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Texas</u>
	17. INFORMANT (ADDRESS) <u>Russell S. Long</u>
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Ever Cemetery</u> DATE <u>July 26</u> , 19 <u>31</u>	
19. UNDERTAKER (ADDRESS) <u>Belva Funeral Home</u>	
20. FILED <u>9-4-</u> , 19 <u>31</u> <u>W. N. West</u> Registrar	

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
(Signed) S. A. Russell, M. D.
(Address) Fairview mo

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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

SUPPLEMENTARY

S-24/V6