

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

16827
Do not use this space.

REC'D JUN 12 1939

1. PLACE OF DEATH

(a) County..... Registration District No.....
 (b) Township..... Primary Registration District No..... Registered No. **4361**
 (c) City **St. Louis, Missouri** Street No. **St. Anthony's Hospital** St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT-FULL NAME *James Ellis Shannon*

(a) Residence, No. **NR** **Rush Tower, Missouri** St. **NR**
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Single**

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **February 17 1861**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
78 2 22

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Farmer**
 9. Industry or business in which work was done, as saw mill, bank, etc. **Retired**
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in the occupation **30 yrs**

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Francios County, Missouri**

FATHER 13. NAME **Thomas Shannon**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Unknown, Tennessee**

MOTHER 15. MAIDEN NAME **Sarah Shelley**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Unknown, Tennessee**

17. INFORMANT (ADDRESS) **W.W. S hannon 4511 Morganford Rd.,**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Festus, Missouri** **May 11, 1939**

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **Albert H. Hoppe Inc 4700 W ashington**

20. FILE **MAY 10 1939** *J. P. Bredick* Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **May 9, 1939**

22. I HEREBY CERTIFY, That I attended deceased from **March 2, 1939** to **May 9, 1939**
 I last saw him alive on **May 9, 1939** Death is said to have occurred on the date stated above, at **12:30 p.m.**
 The principal cause of death and related causes of importance were as follows:

*My judgment is of a heart failure
 (Cystitis & Chronic interstitial nephritis non-calculous non-arteriosclerotic, non-tubercular)*
 Other contributory causes of importance:
arteriosclerosis

Name of operation **Kristalotomy** Date of **3/15/39**
 What test confirmed diagnosis? **Clinical** Was there an autopsy? **No**

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) *W. L. Windy* M. D.
 (Address) **4702 Broadway**

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Albert G. Hoffer

Licensed Embalmer No..... *3971*

P. O. Address.....

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 this body is not embalmed, above space should be left blank.