

Primary Registration District No. 4109

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:  
(a) County Chariton  
(b) City or town Keytesville  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Chariton  
(c) City or town Keytesville  
(d) Street No. \_\_\_\_\_  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years

3. (a) PRINT FULL NAME DAVID RALPH SHANNON

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Sept day 9th year 1942 hour 2 minute 17 M.

3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

21. I hereby certify that I attended the deceased from 12:45 A.M. 9-9-42 to 2 A.M. 9-9-42, 19\_\_\_\_; that I last saw him alive on 9-9-42, 19\_\_\_\_; and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

Immediate cause of death Premature birth

6. (b) Name of husband or wife Betty 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Sept 9th 1942 (Month) (Day) (Year)

Due to vomiting + cramping 12 hrs

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day 2 hr. - min.

Due to acute indigestion 12 hrs.

9. Birthplace Keytesville Mo. (City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation Baby

Major findings: Of operations 159

11. Industry or business \_\_\_\_\_

Of autopsy \_\_\_\_\_

12. Name David Shannon  
13. Birthplace Keytesville Mo. (City, town, or county) (State or foreign country)

PHYSICIAN \_\_\_\_\_ Underline the cause to which death should be charged statistically.

14. Maiden name Michaela Pies  
15. Birthplace Keytesville Mo. (City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_

16. (a) Informant David Shannon  
(b) Address Keytesville Mo.

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

(c) Place: burial or cremation Keytesville  
18. (a) Signature of funeral director W. G. Barrett  
(b) Address Keytesville Mo.

23. Signature Robert Earl Carter, M.D. (M. D. or other) \_\_\_\_\_  
Address Keytesville Mo. Date signed 9-9-42

19. (a) 9/12/42 (Date received local registrar) (b) B. A. Kubing (Registrar's signature)

RECEIVED

District Health Officer No. 8,

District Registrar

Date: 10-8-42

**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.....

Licensed Embalmer No.....

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, fact should be so stated above.**