

NOV 1 1943 149
Registration District No. _____

Primary Registration District No. 1002

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: General Hospital No. 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 Days
(Specify whether years, months or days)

In this community 31 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 1616 Michigan
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME WILLIAM SHANNON

3. (b) If veteran, name war NO 3. (c) Social Security No. 496-07-8481

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

6. (b) Name of husband or wife Mattie Shannon 6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased April 10, 1887
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>56</u>	<u>6</u>	<u>10</u>	hr. _____ min. _____

9. Birthplace Blackburn, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Unemployed

11. Industry or business _____

12. Name Wesley Shannon

13. Birthplace Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Mary (?)

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk

(b) Address General Hospital No. 2

17. (a) Rural (b) Date thereof 10-23-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation HIGHLAND

18. (a) Signature of funeral director [Signature]
(b) Address 1819 E. 1st St. Kansas City

19. (a) 10-22-43 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 20
year 1943 hour 1: minute 45 P.M.

21. I hereby certify that I attended the deceased from Oct. 19
43 to Oct. 20, 1943
that I last saw him alive on Oct. 20, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia

Due to Chr. Arteriosclerotic Nephritis

Due to 13/a

Other conditions (Include pregnancy within 3 months of death) _____

Duration

PHYSICIAN

Major findings: Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(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? _____

While at work? _____ (Specify type of place)

23. Signature [Signature] (M. D. or other) M. D.

Address General Hospital #2 Date signed 10-20-43

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

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..... *John G. Flynn*

Licensed Embalmer No. *2211*

P. O. Address. *1819 E. 15th Str*

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.