DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 13 1944

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 7462

Registration District No. 155 | Primary Registration District No. 3127 | Registrar's No. 10

1. PLACE OF DEATH:

(a) County: Jasper

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

(c) Name of hospital or institution: 423 South Elliott
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days) In this community: 40 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jasper

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

(d) Street No.: 423 South Elliott
(If rural, give location)

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

3. (a) PRINT FULL NAME: Lura Shannon

3. (b) If veteran, name war: No

3. (c) Social Security No. none

4. Sex: F.

5. Color or race: W.

6. (a) Single, widowed, married, divorced: widowed

6. (b) Name of husband or wife: widowed

6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased: August (Month) 22 (Day) 1859 (Year)

8. AGE: Years 84 | Months 5 | Days 15 | If less than one day ____ hr. ____ min.

9. Birthplace: McGomery County (City, town, or county) Illinois (State or foreign country)

10. Usual occupation: at home

11. Industry or business: ____

MOTHER FATHER

12. Name: William Lipe

13. Birthplace: no data (City, town, or county) no data (State or foreign country)

14. Maiden name: no data

15. Birthplace: no data (City, town, or county) no data (State or foreign country)

16. (a) Informant: Dau. Mary Shannon

(b) Address: Webb City, Missouri

17. (a) burial (Burial, cremation, or removal) (b) Date thereof: 2/ 12/ 44 (Month) (Day) (Year)

(c) Place: burial or cremation: Carterville Cemetery

18. (a) Signature of funeral director: Hedge-Nelson

(b) Address: Webb City, Missouri

19. (a) Feb. 12, 1944 (Date received local registrar) (b) Mrs. Lillie Lagle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February Day 7 Year 1944 hour 7 minute A. M.

21. I hereby certify that I attended the deceased from Jan. 10, 1944 to Feb. 7, 1944 that I last saw her alive on Feb. 7, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death: CARCINOMA PYLORIS

Due to: ____

Due to: ____

Other conditions (Include pregnancy within 3 months of death): ____

Major findings:
Of operations: ____
Of autopsy: CA. PYLORIS

Duration

PHYSICIAN

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? ____ (Specify type of place)

While at work? ____ (e) Means of injury: ____

23. Signature: [illegible] (M. D. or other) D.O.

Address: Carterville Date signed 12-10-44

(Licensed Embalmer's Statement on Reverse Side)

44-2-229

Penn e

AUG 10 1956

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. 2889

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.