S. No. 2
OM—5-43
v. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35849

State File No. 1003

FILED NOV 3 1945

Registration District No. ..... Primary Registration District No. ..... Registrar's No. 9916

1. PLACE OF DEATH:
(a) County .....
(b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 days (Specify whether years, months or days)
In this community Lula Shannon

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 212 Carroll
(If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME Lula Shannon
3. (b) If veteran, name war .....
3. (c) Social Security No. .....
4. Sex Femal
5. Color or race Col
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Joseko Shannon
6. (c) Age of husband or wife if alive 36 years
7. Birth date of deceased Nov. (Month) 11 (Day) 1905 (Year)
8. AGE: Years 40 Months ~~11~~ 0 Days ~~13~~ 1 If less than one day ..... hr. ..... min.
9. Birthplace Ark. (City, town, or county) (State or foreign country)
10. Usual occupation House Wife
11. Industry or business .....
MOTHER FATHER
12. Name Savl Reeves
13. Birthplace Mc. (City, town, or county) Ga. (State or foreign country)
14. Maiden name Marry Miller
15. Birthplace ..... (City, town, or county) Tenn. (State or foreign country)
16. (a) Informant Joseko Shannon
(b) Address 212 Carroll
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 11-16-45 (Month) (Day) (Year)
(c) Place: burial or cremation Augusta Ark.
18. (a) Signature of funeral director Kaye & Price
(b) Address 2829 Washington Ave
19. (a) NOV 15 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 12 year 1945 hour 12 minute 20 P.M.
21. I hereby certify that I attended the deceased from 11-3, 1945 to 11-12, 1945; that I last saw her alive on 11-12, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death: Acute Hemorrhagic Pancreatitis — Duration: Acute
Due to .....
Due to .....
Other conditions (Include pregnancy within 3 months of death) .....
Major findings: Of operations .....
Of autopsy See Above

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? .....
While at work? ..... (Specify type of place) (e) Means of injury .....
23. Signature C. A. Hancock (M. D.)
Address 2601 N Whittier St Date signed 11/14/45

(Licensed Embalmer's Statement on Reverse Side)

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 W. Claude Gordon

Licensed Embalmer No. 3489

P. O. Address 4575 Aldine

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.