

X32697

FILED JAN 31 1946
Registration District No. _____

Primary Registration District No. **1003**

Registrar's No. **296**

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer G. Phillips, Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Less than 1 day
(Specify whether
In this community About 40 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County oac
(c) City or town St. Louis
(If outside city or town limits, write "RURAL") 11/7
(d) Street No. 1519 Goode Ave.
(If rural, give location) 9
(e) Citizen of foreign country? None (Yes or No) 1
If yes, name country None

3. (a) PRINT FULL NAME Anna Shannon

3. (b) If veteran, name war None 3. (c) Social Security No. None

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

6. (b) Name of husband or wife William 6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased Mar. 3, 1880
(Month) (Day) (Year)

8. AGE: Years 65 Months 10 Days 4 If less than one day hr. min.

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

10. Usual occupation Seamstress

11. Industry or business None

12. Name Jesse Stanton

13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

14. Maiden name Sophia

15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant William S. Shannon
(b) Address 1519 Goode Ave.

17. (a) Burial (b) Date thereof Jan. 11, '46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Washington Park Cem.

18. (a) Signature of funeral director O. J. Nash

(b) Address 8847 Page

19. (a) JAN 10 1946 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 7th. year 1946 hour 7:00 minute A M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Cerebral Hemorrhage

Due to _____

Due to _____

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

Major findings: _____
Of operations _____

Of autopsy _____

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 injury)
(e) Means of injury 3

23. Signature Catharine E. Taylor, Dep. Clk
Address 1300 Clark Date signed 10-16

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

3109

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.....

E. J. Nash

Licensed Embalmer No.....

2432

P. O. Address.....

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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.