

S. No. 2  
M-5-43  
5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED JAN 6 1948  
Registration District No. 111

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 41350  
Registrar's No. 9292

Primary Registration District No. 5428

1. PLACE OF DEATH:  
(a) County Franklin  
(b) City or town Robertsville  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
own home  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 76 yrs years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State mo (b) County Franklin  
(c) City or town Robertsville, mo Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME JAMES THOMAS SHANNON  
3. (b) If veteran, name war no  
3. (c) Social Security No. none

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Dec day 13 th  
year 1947 hour 9 minute 30 a.m.  
21. I hereby certify that I attended the deceased from  
6-3-47 to 12-13-47  
that I last saw him alive on 12-12-47  
and that death occurred on the date and hour stated above.

4. Sex mc 5. Color or race w  
6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Joanna Shannon (nee Ryan)  
6. (c) Age of husband or wife if alive 73 years  
7. Birth date of deceased July 30, 1870  
(Month) (Day) (Year)

Immediate cause of death  
Chronic Cystitis 24rs-  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

8. AGE: Years 77 Months 4 Days 13  
If less than one day hr. min.

9. Birthplace Robertsville mo  
(City, town, or county) (State or foreign country)  
10. Usual occupation Farming  
11. Industry or business own farm  
12. Name James Shannon  
13. Birthplace unknown Ireland  
(City, town, or county) (State or foreign country)  
14. Maiden name Anna Thomas  
15. Birthplace St. Benigne mo  
(City, town, or county) (State or foreign country)

PHYSICIAN  
Underline the cause to which death should be charged statistically.  
1357

16. (a) Informant ms. Gertrude Heide  
(b) Address Springton, mo  
17. (a) burial (Burial, cremation, or removal) (b) Date thereof Dec 15, 1947  
(Month) (Day) (Year)  
(c) Place: burial or cremation Catawissa, mo  
18. (a) Signature of funeral director Casidy Tenox  
(b) Address St. Clair, mo  
19. (a) Dec 14/47 (Date received local registrar) (b) Mary B. Gross (Registrar's signature) oil

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) (Means of injury)  
23. Signature W. E. Stuchel (M. D. or other) 12/17  
Address St. Clair Date signed \_\_\_\_\_

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

MOTHER FATHER

RECEIVED  
District Health Officer No. 9,  
District File Number 157/48  
Date Filed 1/9/48

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 H. M. Lerrot  
Licensed Embalmer No. 3601  
P. O. Address St. Clair, Mo.

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.