

FILED OCT 8 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31174

BIRTH NO. _____ REG. DIST. NO. 240 PRIMARY REG. DIST. NO. 4358 Registrar's No. 28

1. PLACE OF DEATH: a. COUNTY New Madrid		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY New Madrid	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Lilbourn		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Lilbourn	
c. LENGTH OF STAY (in this place)		72	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location)	
/		2 0	

3. NAME OF DECEASED (Type or Print)	a. (First) Mark	b. (Middle) Franklin	c. (Last) Shanks	4. DATE OF DEATH (Month) (Day) (Year)
				Sept. 20 1949

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Sept. 12 1874	9. AGE (In years last birthday) 75	IF UNDER 1 YEAR Months 0 Days 8	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pensioner	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) LaForge, Missouri.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Mose Shanks	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Voyne Shanks, Lilbourn, Missouri.	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 4 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Brain aneurysm		Anterior flow
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic Bronchitis		
DUE TO (c)		501X	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Sept 15, 1949**, **Sept. 20, 1949**, that I last saw the deceased alive on **Sept 14, 1949**, and that death occurred at **4 A. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Voyne Shanks	23b. ADDRESS Missouri	23c. DATE SIGNED 10/2/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Sept. 21 1949	24c. NAME OF CEMETERY OR CREMATORY Memorial Park	24d. LOCATION (City, town, or county) (State) Sikeston, Missouri.
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DATE REC'D BY LOCAL REG. Oct. 4 1949	REGISTRAR'S SIGNATURE H. L. Ponder Deputy	25. FUNERAL DIRECTOR'S SIGNATURE Ponder Funeral Home, Lilbourn, Mo.	ADDRESS
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(Licensed Emballer's Statement on Reverse Side)

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

RECEIVED OCT 5
District Health Office
District File Number 1049
Date Filed

907 1 01949

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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed, *Homer L. Ponder*

Licensed Embalmer No. *3367*

P. O. Address *Lillbourn, Mo.*

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

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