

FILED SEP 15 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 28662

318

1003

Registrar's No. 7651

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE _____ b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN _____		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN _____		221 N. Grand Blvd. Mo. 2219	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION _____				d. STREET ADDRESS (If same, give location) _____			
St. John's Hospital				221 N. Grand Blvd.			
3. NAME OF DECEASED a. (First) _____ b. (Middle) _____ c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year)				
Rev. James I. Shannon S.J.			Sept. 8, 1950				
5. SEX _____	6. COLOR OR RACE _____	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) _____	8. DATE OF BIRTH _____	9. AGE (In years last birthday) _____	IF UNDER 1 YEAR _____	IF UNDER 2 HRS. _____	
Male	White	Single	Sept 30, 1868	81			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) _____		12. CITIZEN OF WHAT COUNTRY? _____
Jesuit Priest					Canada		U.S.
13a. FATHER'S NAME _____			13b. MOTHER'S MAIDEN NAME _____		14. NAME OF HUSBAND OR WIFE _____		
James Shannon			Dont Know		None		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME _____ ADDRESS _____			
				Rev. Valentine Roach S.J. 221 N. Grand Av			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH _____
		Sub-phrenic abscess (Post-operative)					1 mo.
		Cholecystectomy for Acute Cholecystitis					operated July 28-50
		None					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
7-28-50		Common duct drained for acute pancreatitis					
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) _____			
No							
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
				587.0			
22. I hereby certify that I attended the deceased from _____, 1950, to _____, 1950, that I last saw the deceased alive on _____, 1950 and that death occurred at _____, from the causes and on the date stated above.							
23a. SIGNATURE _____ (Degree or title) _____				23b. ADDRESS _____		23c. DATE SIGNED _____	
John J. Hammond M.D.				634 N. Grand		9/19/50	
24a. BURIAL, CREMATION, REMOVAL (Specify) _____		24b. DATE _____		24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) _____	
Burial		9-12-50		St. Stanislaus Seminary		Florissant Mo.	
DATE REC'D BY LOCAL REG. _____		REGISTRAR'S SIGNATURE _____		25. FUNERAL DIRECTOR'S SIGNATURE _____ ADDRESS _____			
SEP 10 1950		J. B. Kasater		Arthur J. Donnelly 3840 Lindell Blvd			

(Licensed Embalmer's Statement on Reverse Side)

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

**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.....

*W VanMatre*

Licensed Embalmer No. *2825*

P. O. Address *4340 Lafayette*

**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.**