

Public Welfare Service

FILED JUN 24 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE NUMBER 57-02305 28

Registration District No. 373 Primary Registration District No. 457J Registrar's No.

1. PLACE OF DEATH a. COUNTY WEBSTER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY WEBSTER	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN MARSHFIELD		c. CITY OR TOWN MARSHFIELD	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location)	
Length of stay in lb		203 N. Main 112	
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First CATHERINE Middle SHANNON Last SHANNON			4. DATE OF DEATH Month JUNE Day 10 Year 1957		
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 28 1876	9. AGE (In years last birthday) 81	10. UNDER 1 YEAR Months Days Hours	11. 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) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) MISSOURI	12. CITIZEN OF WHAT COUNTRY? U.S.A
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13a. FATHER'S NAME WILLIAM MARTIN	13b. MOTHER'S MAIDEN NAME SARAH MORTON	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.	17. INFORMANT ROBERT SHANNON Address SPRINGFIELD
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CIRCULATORY FAILURE PULMONARY OEDEMA CORONARY OCCLUSION DUE TO (b) ARTERIO SCLEROSIS DUE TO (c) ARTERIO SCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART-II of item 18.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from did not attend - County Health Officer Death occurred at 12:30 AM on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) J. Blinn M.D.	22b. ADDRESS 2 Marshfield, Mo.	22c. DATE SIGNED 6/10/57
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 6-12-1957	23c. NAME OF CEMETERY OR CREMATORY MARSA-FIELD	23d. LOCATION (City, town, or county) (State) MARSHFIELD MO
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24. FUNERAL DIRECTOR BARBER-EDWARDS	ADDRESS MARSHFIELD	25. DATE RECD. BY LOCAL REG. 6/21/57	26. REGISTRAR'S SIGNATURE J. Stranen
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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
Signature of Student Embalmer

Signed *George Stoffe*

Licensed Embalmer No. *3161*

P. O. Address *Mt. Zion, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting:
If this body is not embalmed, fact should be so stated above.