

U.S. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-036821

FILED VS. OCT 26 1959, 84

Registration District No. 184 Primary Registration District No. 3038 Registrar's No. 109

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <u>Linn</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Linn</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Brookfield</u>	Length of stay in Tb <u>17 years</u>	c. CITY OR TOWN <u>Brookfield</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>420 South Caldwell</u>		d. STREET ADDRESS (If outside, give location) <u>420 South Caldwell</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Shannon</u> Last <u>Shannon</u>	4. DATE OF DEATH Month <u>October</u> Day <u>15</u> Year <u>1959</u>
--	---

5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5/12/1873</u>	9. AGE (last birthday) <u>86</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>3</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
--------------------	---------------------------------	--	-----------------------------------	----------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>of Bank of homes</u>	11. BIRTHPLACE (City and state or country) <u>Brunswick, Md.</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
--	---	--	---

13a. FATHER'S NAME <u>Andrew Jackson Shannon</u>	13b. MOTHER'S MAIDEN NAME <u>Maria Washington</u>	14. NAME OF HUSBAND OR WIFE <u>Riley Shannon (deceased)</u>
--	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>Nannie Hopkins, Brunswick, Mo.</u>
--	-------------------------------------	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>	INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
---	--

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.) _____
--	---	--

20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	Month, Day, Year _____
---	------------------------

20d. INJURY OCCURRED WHILE AT WORK <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 _____
--	--	------------------------------------	--------------	-------------

21. I attended the deceased from 10-8-59 to 10-15-59 and last saw ^{her}him alive on 10-15-59
Death occurred at 11:40 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>W. H. Potter</u>	22b. ADDRESS <u>Brookfield Mo</u>	22c. DATE SIGNED <u>10-17-59</u>
--	-----------------------------------	----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Oct. 19, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery, Brookfield, Missouri</u>	23d. LOCATION (City, town, or county) (State) _____
---	--------------------------------	--	---

24. FUNERAL DIRECTOR <u>Will Funeral Home, Brookfield, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>10-19-59</u>	26. REGISTRAR'S SIGNATURE <u>Katharine Johnson</u>
--	--	--

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Harold I. Wady

Licensed Embalmer No. 4172

P. O. Address Brown

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.