S. No. 2
M—8-43
. 5-17-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 31670

FILED SEP 28 1944

Registration District No. 2044 Primary Registration District No. 3059 Registrar's No. 169

1. PLACE OF DEATH:
(a) County St. Francois
(b) City or town Bonne Terre
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
149 Middle
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St Francois
(c) City or town Bonne Terre
(If outside city or town limits, write "RURAL")
(d) Street No. 149 Middle
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME THOMAS JEFFERSON SHANNON
3. (b) If veteran, name war V
3. (c) Social Security No. UNKNOWN

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced WIDOWED
6. (b) Name of husband or wife WILLIE MAE SHANNON
6. (c) Age of husband or wife if alive V years
7. Birth date of deceased April (Month) 13 (Day) 1868 (Year)

8. AGE: Years 76 Months 5 Days 2 If less than one day hr. min.

9. Birthplace Elvira (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Retired
11. Industry or business

MOTHER FATHER
12. Name Joseph Shannon
13. Birthplace Unknown (City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Harold Shannon
(b) Address Bonne Terre Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 17-1944 (Month) (Day) (Year)
(c) Place: burial or cremation B.T. Cemetery
18. (a) Signature of funeral director Benham & Cuddo
(b) Address 313 Benham Bonne Terre Mo
19. (a) 9-19-44 (Date received local registrar) (b) Conrad S Johnson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 15th.
year 1944 hour 1 minute 20 P. M.
21. I hereby certify that I attended the deceased from Aug 26 1944 to Sept 15 1944
that I last saw him alive on Sept 13 1944
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Acute dilatation of heart	
Due to Severe Mitral Leak	
Due to Brights disease V	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
Of autopsy

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

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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature B H Lamb (M. D. or other)
Address Bonne Terre Date signed 9/19/44

1373

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 4

District File Number 944-4333

Date Filed 9-26-44

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 C J Claywell

Licensed Embalmer No. 3706

P. O. Address Bonne Terre

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.

Form No. 2B
5-43
X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Oct

Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 169

1. PLACE OF DEATH:
(a) County St Francois
(b) City or town Bonne Terre
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

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

3. (a) PRINT FULL NAME Thomas J. Shannon
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased April (Month) 13 (Day) 1868 (Year)
8. AGE: Years 76 Months 5 Days If less than one day hr. min.
9. Birthplace (City, town, or county) Mo. (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept 18 year 1944 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19;
that I last saw h alive on 19;
and that death occurred on the date and hour stated above.
Immediate cause of death acute dilatation of heart — Duration
Due to Severe Mitral Leak
Due to Brights Disease Chronic
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature B. J. Marler (M. D. or other) DO
Address Date signed

SUPPLEMENTARY

1316

31670