

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REC'D APR 12 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

8584
Do not use this space.

1. PLACE OF DEATH

(a) County.....² Registration District No.....⁷⁹¹
(b) Township.....¹ Primary Registration District No.....¹⁰⁰⁸ Registered No.....²³⁴⁹
(c) City.....St. Louis, (d) Street No.....2209 Hebert St. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME ⁵⁵⁰ Catherine Shannon.

(a) Residence, No. 2209 Hebert St. St. 20 (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single.</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>July 19th, 1869</u>		
7. AGE	YEARS <u>69</u>	MONTHS <u>7</u>
	DAYS <u>22</u>	IF LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>At Home.</u>	
	9. Industry or business in which work was done, as saw mill, bank, etc. _____	
	10. Date deceased last worked at this occupation (month and year) _____	11. Total time (years) spent in this occupation _____
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ireland.</u>	<u>5</u>	
FATHER	13. NAME <u>Daniel Shannon.</u>	<u>5</u>
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ireland.</u>	<u>5</u>
MOTHER	15. MAIDEN NAME <u>Catherine Hennessey.</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ireland.</u>	
17. INFORMANT (ADDRESS) <u>Mrs. J. H. Harris.</u> <u>3622 Clark Ave.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Calvary</u>	DATE <u>Mar. 13, 1939.</u>	
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Arthur J. Donnelly.</u> <u>3840 Lindell Blvd.</u>		
20. FILED <u>MAR 12 1939</u>	<u>J. B. Budick</u> Local Registrar	

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 11, 1939.

22. I HEREBY CERTIFY, That I attended deceased from Feb. 15, 1939 to March 11, 1939
I last saw her alive on March 11, 1939 Death is said to have occurred on the date stated above, at 10:00 A.M.
The principal cause of death and related causes of importance were as follows:
Chronic Myocarditis
Date of onset _____

Other contributory causes of importance:
Arteriosclerosis

Name of operation None. Date of _____
What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No.
If so, specify _____
(Signed) Anthony A. Prekavick, M.D.
(Address) 1525 a Cass Ave.

Dr. V. Marchlewski
1525-a Cass in

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 Stanley Marchlewski

Licensed Embalmer No. 2868

P. O. Address 3840 Lindell

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, above space should be left blank.