

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.

Registration District No. **318** Primary Registration District No. **2001**

1. PLACE OF DEATH:
(a) County **Greene**
(b) City or town **Springfield**
(c) Name of hospital or institution: **210 E. PARK**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Greene**
(c) City or town **Springfield**
(If outside city or town limits, write "RURAL")
(d) Street No. **210 E. Park**
(If rural, give location)
(e) If foreign born, how long in U. S. A.?

3. (a) PRINT FULL NAME **ABRAHAM FRANTZ SHANNON**
3. (b) If veteran, name war
3. (c) Social Security No. **556**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **12** day **18** year **1936** hour **3:15** minute **P** M.

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **KATE E SHANNON**
6. (c) Age of husband or wife if alive **28** years (Month) **August** (Day) **28** (Year) **1853**

21. I hereby certify that I attended the deceased from **11-20-39**, 19 to **12-18-39**, 19; and that death occurred on the date and hour stated above.

8. AGE: Years **86** Months **3** Days **20** If less than one day **—** min.

Immediate cause of death **Degenerative Heart Disease**
Generalized Arteriosclerosis
Due to **Senility**

9. Birthplace **Indiana Pa.** (City, town or county) (State or foreign country)

Due to
Other conditions (Include pregnancy within 3 months of death) **QTC**

10. Usual occupation **Church Florist**

PHYSICIAN
Major findings: Of operations
Of autopsy

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

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?

16. (a) Informant's own signature **Katie Shannon**
(b) Address **Springfield, Mo.**

While at work? (Specify type of place) (e) Means of injury
Signature **J. Simpson M.D.** (M. D. or other)
Address **Springfield, Mo.** Date signed **12-19-39**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Dec 20, 1936** (Month) (Day) (Year)
(c) Place: burial or cremation **Maple Park**

18. (a) Signature of funeral director **J. W. Agnew**
(b) Address **Springfield, Mo.**
19. (a) **12/19/39** (Date received local registrar) (b) **Chas. H. George, M.D.** (Registrar's signature)

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.....

Licensed Embalmer No.....

P. O. Address.....

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.