DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 40785

Registration District No. 791 — Primary Registration District No. 1003 — Registrar's No. 10556

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

1. PLACE OF DEATH:
(a) County DESLOGE HOSPITAL
(b) City or town ____ (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 years, months or days)
In this community ____

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County ____
(c) City or town ST. LOUIS (If outside city or town limits, write "RURAL") 5
(d) Street No. 1289a HODIAMONT AV. (If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME Michael Shannon
3. (b) If veteran, name war ____
3. (c) Social Security No. 492-09-3152
4. Sex MALE
5. Color or race WHITE
6. (a) Single, widowed, married, divorced SINGLE
6. (b) Name of husband or wife ____
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased MARCH (Month) 27 (Day) 1878 (Year)
8. AGE: Years 62 ~~65~~ Months 8 Days 23 If less than one day ____ hr. ____ min.
9. Birthplace ____ (City, town, or county) (State or foreign country) 5
10. Usual occupation MACHINE OPERATOR
11. Industry or business WAGNER ELEC. CO. 5
FATHER 12. Name MICHAEL SHANNON
13. Birthplace IRELAND (City, town, or county) (State or foreign country) 5
MOTHER 14. Maiden name MARGARET GARASHEE
15. Birthplace IRELAND (City, town, or county) (State or foreign country)
16. (a) Informant Peter Shannon
(b) Address 1289A Hodiamont
17. (a) ____ (Burial, cremation, or removal) (b) Date thereof 12 23 40 (Month) (Day) (Year)
(c) Place: burial or cremation CALVARY CEMETERY
18. (a) Signature of funeral director Meek & Dickman
(b) Address 2039 Easton Ave.
19. (a) DEC 23 1940 (Date received local registrar) (b) J. H. Budich (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12-20-40 day ____ year ____ hour 5-20 P.M. minute ____ M.
21. I hereby certify that I attended the deceased from 11/26/40, 19__, to 12/20/40, 19__; that I last saw him alive on 12/20/40, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of liver & metastases — Duration ____
Due to ____
Due to ____
Other conditions (Include pregnancy within 3 months of death) ____
Major findings: Of operations ____
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 Geo. W. Flynn (M. D. or other)
Address Fenton Desloge Date signed 12/21/40

(Licensed Embalmer's Statement on Reverse Side)

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 Arnold W. Schoene

Licensed Embalmer No. 3864

P. O. Address St. Louis Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.