

11-39
X2142

REG. MAR 17 1941
Registration District No. 461

Primary Registration District No. 3024

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Lafayette
(b) City or town Lexington
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1510 Lafayette St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community Life time years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Virginia (b) County Lafayette
(c) City or town Lexington, Virginia
(If outside city or town limits, write "RURAL")
(d) Street No. 1510 Lafayette 3
(If rural, give location) 2
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 1st
year 1941 hour 1 minute 05 M.
21. I hereby certify that I attended the deceased from April
18th, 1940 to Feb. 1st, 1941;
that I last saw her alive on Feb. 1st, 1941
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Severe influenza
and Bronchopneumonia
due to Septicemia
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Carcinoma
Of operations _____
Of autopsy none

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?
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature J. P. West (M. D. or other) _____
Address Lexington, Va Date signed 2/3/41

3. (a) PRINT FULL NAME ELIZA SHANNON

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race Col 6. (a) Single, widowed, married, divorced, widow

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: September 29 1869
(Month) (Day) (Year)

8. AGE: Years 71 Months 7 Days 28 If less than one day _____ hr. _____ min.

9. Birthplace Lafayette, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name James Warden Colley

13. Birthplace Lafayette, Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Harrison

15. Birthplace Spencerburg, Virginia
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Endelia Edd

(b) Address 1510 Lafayette St.

17. (a) Burial (b) Date thereof 2-4-1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation West Lawn

18. (a) Signature of funeral director George W. ...
(b) Address 207 So. 2nd St. Lexington, Va.

19. (a) Mar 14/41 (b) Delia Bates
(Date received local registrar) (Registrar's signature)

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

55

RECEIVED
District Health Officer No. 8,
District File Number
3-12-41
Date Filed

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

George H. Green, Registered Apprentice No. 235
working under my personal supervision.

Signed William H. Finley

Licensed Embalmer No. 3105
204 South 24th Street
P. O. Address Lexington, Mass.

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

7396
Do not use this space.

1. PLACE OF DEATH
 (a) County Lafayette Registration District No. #61
 (b) Township Primary Registration District No. 3024 Registered No.
 (c) City Lexington (d) Street No. 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 Eliza Shannon
 (a) Residence, No. St. (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 F 4. COLOR OR RACE col 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>71</u>	<u>7</u>	<u>28</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 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)

FATHER

13. NAME
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER

15. MAIDEN NAME
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
 PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 1 1941

22. I HEREBY CERTIFY, That I attended deceased from to 19.....

I last saw h..... alive on 19..... Death is said to have occurred on the date stated above, at m.
 The principal cause of death and related causes of importance were as follows:

Influenza
Bacterial Pneumonia
of the Epitheliomatous
(Squamous cell)
carcinoma
(vagina) primary

Other contributory causes of importance:
(Squamous cell)
carcinoma
(vagina) primary

Name of operation Date of
 What test confirmed diagnosis? Was there an autopsy?

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?
 If so, specify (Signed) J. D. Hersh M. D.
 (Address) 712 Franklin Co. Lexington, Mo.

SUPPLEMENT

Local Registrar.

wa (m) Lexington Mo

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
 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.

