V. S. No. 2
DM—11-10-39
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 27467

D SEP 7 1943

Registration District No. 49

Primary Registration District No. 002

Registrar's No. 3678

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Vineyard Park Hosp. 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 Days (Specify whether
In this community 6 Days years, months or days)

2. USUAL RESIDENCE OF DECEASED: 999

(a) State Kansas (b) County Franklin 14

(c) City or town Wellsville 0
(If outside city or town limits write "RURAL")

(d) Street No.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 2 years.

3. (a) PRINT FULL NAME Hallie Shannon

3. (b) If veteran, name war no

3. (c) Social Security No. 509-10-3113

4. Sex Fe

5. Color or race Wh

6. (a) Single, widowed, married, divorced Divorced 3

6. (b) Name of husband or wife Unknown

6. (c) Age of husband or wife if alive — years

7. Birth date of deceased Nov. 4 1900
(Month) (Day) (Year)

8. AGE: Years 42 Months 9 Days 20 If less than one day hr. min.

9. Birthplace Wellsville Kansas 1
(City, town, or county) (State or foreign country)

10. Usual occupation Waitress

11. Industry or business

FATHER
12. Name Calvin S. Stephens
13. Birthplace Wellsville Kansas 1
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Lula M. Dawson
15. Birthplace Ind. 1
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital Records
(b) Address KC Mo

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 8-27-43 (Month) (Day) (Year)
(c) Place: burial or cremation Wellsville Kansas

18. (a) Signature of funeral director Coughlin Funeral Home
(b) Address Wellsville Kansas

19. (a) 8-25-43 (Date received local registrar) (b) T. E. Bracon (Registrar's signature) Dep

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 24 year 1943 hour 9:15 PM minute M.

21. I hereby certify that I attended the deceased from Aug 18 1943, to Aug 24 1943; that I last saw her alive on Aug 24 1943; and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Embolism — Duration 7 hrs.

Due to Uterine Fibromas Pyosalpingitis 56 1/2 — 1 yr.

Due to

Other conditions Pelvic cellulitis — pain old laparotomy
(Include pregnancy within 3 months of death)

Major findings: Of operations Fibroids & Pustule

Of autopsy None

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 [signature] (M. D. or other)

Address 922 Avenue [illegible] Date signed 8-25-43

(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 O. H. Beckwith

Licensed Embalmer No. 3927

P. O. Address Kansas City, Kansas

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.