

OCT 11 1943
Registration District No. **214**

Primary Registration District No. **5778A**

Registrar's No. _____

1. PLACE OF DEATH:
(a) County **Miller**
(b) City or town **St. Elizabeth Rural**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **At Home**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **Yes**
years, months or days

3. (a) PRINT FULL NAME **Elvie Lee Shannon**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Female** 5. Color **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 **Sept 3 1943**
(Month) (Day) (Year)

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

9. Birthplace **St Elizabeth Mo** (City, town, or county) (State or foreign country)

10. Usual occupation **Infant**

11. Industry or business _____

12. Name **Elvie Lee Shannon**

13. Birthplace **Lebanon Georgia** (City, town, or county) (State or foreign country)

14. Maiden name **Lucy Rose Andrews**

15. Birthplace **St Elizabeth Mo** (City, town, or county) (State or foreign country)

16. (a) Informant **John B. Hodes**

(b) Address **St Elizabeth Mo**

17. (a) **Mount Zion** (Burial, cremation or removal) (b) Date thereof **Sept 10 1943** (Month) (Day) (Year)

(c) Place: burial or cremation **Mount Zion Mo**

Signature of funeral director **H. H. Drake**

Address **Miller Mo**

9-10-1943 (b) **Wm. S. Schroeder** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **Miller**
(c) City or town **St Elizabeth Mo** (If outside city or town limits, write "RURAL")
(d) Street No. **Rural** (If rural, give location)
(e) If foreign born, how long in U. S. A.? **0** years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **10th**
year **1943** hour **2 A.M.** minute _____ M.
21. I hereby certify that I attended the deceased from **Sept 3rd** 19**43** to **Sept 10** 19**43**
that I last saw him alive on **Sept 5th** 19**43**
and that death occurred on the date and hour stated above.

Immediate cause of death: **Perinatal Myocarditis** Duration **7 days**

Due to **Complication to other Pregnancy with typhoid & Pneumonia**

Due to _____
Other conditions: (Include pregnancy within 3 months of death) **1572**

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **W. E. Humphreys** (M. D. or other) **D.O.**
Address **Columbia Mo** Date signed **9-10-43**

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

MOTHER FATHER

RECEIVED

Warner County Health Dep't.

County File Number 43-80

Date Filed 10-6-43

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 do so constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.