V. S. No. 2
100M—2-43
Rev. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 27 1944

Registration District No. 318

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 976

Registrar's No. 534

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 11 days (Specify whether years, months or days)

In this community 50 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis,
(If outside city or town limits, write "RURAL")

(d) Street No. 28 N. Market
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Robert Shannon

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race Negro

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Lulu Shannon

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

7. Birth date of deceased Unknown (Month) 1875 (Day) (Year)

8. AGE: Years abt 68 | Months — | Days — | If less than one day hr. min.

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

10. Usual occupation Laborer

11. Industry or business Coal company

FATHER
12. Name ? Shannon
13. Birthplace Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Lorraine Crockett
(b) Address 2704 Delamr Blvd.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 19 44 (Month) (Day) (Year)
(c) Place: burial or cremation Greenwood Cem.

18. (a) Signature of funeral director Russell Undt. Co.
(b) Address 2732 Pine Street

19. (a) JAN 18 1944 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 13, year 1944 hour 6 minute 06 A. M.

21. I hereby certify that I attended the deceased from January 2, 1944, to January 13, 1944; that I last saw him alive on January 13, 1944; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hypertensive Heart Disease	Unk.
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 H. E. Smith (M. D. or other)

Address 2601 Whittier Date signed 1/14/44

(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 Joel Russell

Licensed Embalmer No. 4112

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, fact should be so stated above.