DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 11 1948

Registration District No. 65

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 15713

Primary Registration District No. 4115

Registrar's No. 68

1. PLACE OF DEATH:
(a) County: Chariton
(b) City or town: Triplett
(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: Mo (b) County: Chariton 21
(c) City or town: Triplett 0
(If outside city or town limits, write "RURAL") 0
(d) Street No. ____ 0
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: William S Shannon
3. (b) If veteran, name war ____ 3. (c) Social Security No. ____
4. Sex: M 0
5. Color or race: W
6. (a) Single, widowed, married, divorced: widowed
6. (b) Name of husband or wife ____ 6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased: July (Month) 12 (Day) 1876 (Year)
8. AGE: Years 71 Months 10 Days 13 If less than one day ____ hr. ____ min.
9. Birthplace: Hale Mo. (City, town, or county) Ralls (State or foreign country) 0
10. Usual occupation: Farmer
11. Industry or business ____
FATHER 12. Name: James N Shannon
13. Birthplace: Ohio (City, town, or county) ____ (State or foreign country) /
MOTHER 14. Maiden name: Helen McAllister
15. Birthplace: Maine (City, town, or county) ____ (State or foreign country) /
16. (a) Informant's own signature: Lou Shannon
(b) Address: Triplett Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 5/27/48 (Month) (Day) (Year)
(c) Place: burial or cremation: Lakeside Cemetery Mo
18. (a) Signature of funeral director: S. L. Leipard
(b) Address: Meadville Mo
19. (a) 5-27-48 (Date received by local registrar) (b) Mildred Boone (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 25 year 1948 hour 10: minute 30 A.M.

21. I hereby certify that I attended the deceased from AUGUST 2, 1947 to MAY 25, 1948; that I last saw him alive on MAY 22, 1948; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: ANGINA PECTORIS	1 YEAR
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations: 94 P	
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 ____ 2

23. Signature: Kenneth L Rosenbaum (M. D. or other) D.O.
Address: TRIPLETT, Mo. Date signed 5-26-48

(Licensed Embalmer's Statement on Reverse Side)

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

N. B.—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.

Rev. 1-1-46 Form 1 X19311

RECEIVED
District Health Officer No. 8,
District File Number.....
Date Filed 6-10-48

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 S. L. Leipard

Licensed Embalmer No. 3970

P. O. Address Mendon M

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.