

FILED NOV 12 1948

**318**

Primary Registration District No. **1003**

Registration District No. \_\_\_\_\_

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:  
St. Louis City Hospital - Max C. Starkloff  
(If not in hospital or institution, write street number or location) **Memorial**  
(d) Length of stay: In hospital or institution 1 (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME THOMAS JOHN SHANNON

3. (b) If veteran, name war No 3. (c) Social Security No. 488-0708857

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife Catherine Shannon 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased August 1880  
(Month) (Day) (Year)

8. AGE: Years 68 Months 2 Days 22 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Shoe Worker

11. Industry or business International Shoe Co.

12. Name Thomas Shannon

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

14. Maiden name Julia Carten

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

16. (a) Informant Mrs. Frances Holubeck,

(b) Address 2313a Cass Ave.

17. (a) Burial (b) Date thereof 10-30-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Calvin Bros.

(b) Address 3320 N. Kingshighway Bl.

19. (a) OCT 29 1948 J. B. Sater  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1717a O'Fallon St.  
(If rural, give location)  
(e) Citizen of foreign country? 25 (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 28th  
year 1948 hour 4 minute 35 A.M.

21. I hereby certify that I attended the deceased from 10/4/48  
to Oct. 28th, 19 48  
that I last saw h im alive on Oct. 28th, 19 48  
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerosis heart disease 2  
Duration \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions Cerebral aneurysm of right  
(Include pregnancy within 3 months of death) legion, primary site undetermined

Major findings: PHYSICIAN  
Of operations \_\_\_\_\_

Of autopsy not permitted  
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 J. B. Sater (M. D. or other) \_\_\_\_\_  
Address 1505 Lafayette 10/28/48  
Date signed

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

MOTHER FATHER

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**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 *Fred Frick*.....

Licensed Embalmer No. 3186.....

P. O. Address. St. Louis, Mo......

**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.**