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Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

31493

FILED SEP 23 1957

STATE FILE NUMBER  
889-A

Registration District No. 128 Primary Registration District No. 2000

Registrar's No. 889-A

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>GREENE</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>SPRINGFIELD</b>		c. CITY OR TOWN <b>BOIS D'ARC</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BURGE HOSPITAL</b>		d. STREET ADDRESS <b>2 wks</b>	

3. NAME OF DECEASED (Type or print) First Middle Last <b>OLIVER THOMAS SHANNON</b>			4. DATE OF DEATH Month Day Year <b>Sept. 11, 1957</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 22, 1877</b>	9. AGE (In years last birthday) <b>79</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Marine Clerk</b>	10b. KIND OF BUSINESS OR <b>Madison Navigation Co.</b>	11. BIRTHPLACE (City and state or country) <b>Arkansas</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Unknown</b>	13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Edith Shannon</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <b>?</b>	17. INFORMANT Address <b>Mrs. Edith Shannon, Bois D'Arc, Mo.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage (Eptemin)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 Days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Cerebral Hemorrhage</b>	<b>16 Days</b>
	DUE TO (c) <b>Hypertensive Cordis Vascularia</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from <b>8/26/57</b> to <b>9/11/57</b> and last saw him alive on <b>9/11/57</b> Death occurred at <b>10:45 a.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Date or title) <b>David Hail M.D.</b>	22b. ADDRESS <b>Springfield, Missouri</b>	22c. DATE SIGNED <b>9-12-57</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>9-14-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Clear Creek Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Greene County, Mo.</b>
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24. FUNERAL DIRECTOR <b>AYRE-GOODWIN, Inc. Springfield</b>	25. DATE RECD. BY LOCAL REG. <b>9-16-57</b>	26. REGISTRAR'S SIGNATURE <b>Edith Williamson</b>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *Lucius T. Swalley* .....

Licensed Embalmer No. *4815* .....

P. O. Address *Springfield* .....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.