

N. B.—WRITE FULLY, WITH UNFADING INK—THIS A PERMANENT RECORD. 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. See instructions on back of certificate.

MISSISSIPPI STATE BOARD OF HEALTH

Bureau of Vital Statistics

CERTIFICATE OF DEATH

12908

1 PLACE OF DEATH
 County Copiah State Miss Registration District No. 706 File No.
 Village _____ Vol. Pct. Glancy or Primary Registration Dist. No. 5371 Reg. No. 1182
 City _____ No. _____ St. _____ Ward _____
 (If death occurred in a hospital or institution give its NAME instead of street number.)

2 FULL NAME Ann Shannon

(a) Residence (Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Col 5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word) married

5a If married, widowed, or divorced
 HUSBAND of _____
 (or) WIFE of _____

6 DATE OF BIRTH (month, day and year)

7 AGE YEARS MONTHS DAYS IF LESS than
60 1 day, hrs. min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Work

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Copiah

PARENTS

10 NAME OF FATHER Arthur Brown

11 BIRTHPLACE OF FATHER (city or town)

(State or Country) Dan

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town)

(State or Country) Dan

14

Informant Ben Shannon

(Address) Glancy

15

Filed _____

19 _____

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

(Month, day and year) July 4 1927

17. I HEREBY CERTIFY, That I attended the deceased from July 1927 to July 1927 that I last saw him alive on July 1927

and that death occurred on the date stated above, at _____ mi.
 The CAUSE OF DEATH* was as follows:

apoplexy with
paralysis

(duration) yrs mos ds.

CONTRIBUTORY

(Secondary)

(duration) yrs mos ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? _____

date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

Signed _____

19 _____

19 _____ (Address)

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal or Homicidal.

19 Place of Burial, Cremation or Removal

Date of Burial

Moskian Church

7-4-1927

20 UNDERTAKER

ADDRESS

Agony Closet Seller