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.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County Worth

Township Hatchtown

or

Village

or

City Grant City (NO. St. Ward)

Registration District No. 903 File No. 17225

Primary Registration District No. 4515 Registered No. 10

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Geo Ira Cannes

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: June 20 (Month) (Day) 1851 (Year)

7 AGE: 73 yrs. 10 mos. 15 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry business, or establishment in which employed (or employer): "

9 BIRTHPLACE (City or town, State or foreign country): Ga

PARENTS

10 NAME OF FATHER: Jas Robert Cannes

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Do not know

12 MAIDEN NAME OF MOTHER: Do not know

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): "

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. H. Cannes

(Address) Grant City Mo

15 Filed May 7 1925 John Andrews Registrar

3 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: May (Month) 5 (Day), 1925 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan, 1925, to May 5, 1925, that I last saw him alive on May 4, 1925, and that death occurred, on the date stated above, at 2 - 9 a.m.

The CAUSE OF DEATH* was as follows:

Cardio Vascular disease

Endocarditis 90

(Duration) ..... yrs. 4 mos. - ds.

CONTRIBUTORY (Secondary) Epithelioma

(Duration) 4 yrs. - mos. - ds.

(Signed) J. C. Phipps M. D.

May 5, 1925 (Address) Grant City Mo

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

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the state ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Grant City Cemetery DATE OF BURIAL: May 7, 1925

20 UNDERTAKER: Orr Funeral ADDRESS: Grant City Mo

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or gi[redacted] of the DISEASE CAUSING DEATH, st[redacted] beginning of illness. If retired fr[redacted] fact may be indicated thus: *Farm[redacted]* For persons who have no occu[redacted] write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of.....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "*Asthenia*," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by rail-*[redacted] *head—suicide.* [redacted] ull, and [redacted] stated [redacted] menda- [redacted] tions on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

It is essential that death certificates be made complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate:

Name: George Dra Carnes

Who died at: Grant City on May 5-1925.

Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____

Sex: _____ Color or race: _____ Single, married, widowed or divorced: _____

Date of birth: _____ Age: Years ____ Months _____ Days _____

Occupation: (a) Trade _____ (b) Industry: _____

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

CAUSE OF DEATH: Cardiac Vascular disease

Endocarditis

Contributory: Epithelioma

Nose cancer of Epithelioma

Where was disease contracted? _____

Did operation precede death? _____ Date of _____

Was there an autopsy? _____ What test confirmed diagnosis? _____

Name of physician: _____

Address of physician: _____

17225