

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

Do not use this space.

MAR 25 1930

85

4190

1. PLACE OF DEATH

County Buchanan Registration District No. 1001
Township _____ Primary Registration District No. _____
City St. Joseph (No. Noyes Baptist Hospital)

File No. _____
Registered No. 260
St. _____ Ward _____

2. FULL NAME James Cannon

(a) Residence No. 1803 St. Joseph Ave. St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)

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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Single

6. DATE OF BIRTH (MONTH, DAY AND YEAR) About 1839

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
81 UNKNOWN

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Unknown
(STATE OR COUNTRY) New York

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Unknown

14. INFORMANT Hospital Records
(Address) Noyes Baptist Hos. St. Joseph Mo

15. FILED 6 1930 REGISTRAR John G. [Signature]

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) February 28 1930

17. I HEREBY CERTIFY, That I attended deceased from Feb 25, 1930 to Feb 27, 1930 that I last saw him alive on Feb 27, 1930 and that death occurred, on the date stated above, at 2:50 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocarditis chr.

CONTRIBUTORY (SECONDARY) Several
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH. No. DATE OF _____
WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS autops & clinical
(Signed) Dr. F. [Signature], M. D.

(Address) St. Joseph Mo
*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 City Cemetery DATE OF BURIAL Mar. 6 1930

20. UNDERTAKER M. C. Dickerson ADDRESS 1802 Union St

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.

