

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

Do not use this space.

6809

1. PLACE OF DEATH

County Registration District No. **791**
 Township Primary Registration District No. **1003**
 City **St. Louis Mo.** (No. **1116** & **Montgomery St.**) St. Ward)

File No.
 Registered No. **1645**
 St. Ward)

2. FULL NAME

James A. Cannon
 (a) Residence No. **1116** & **Montgomery St.**, **26** Ward. (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) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Nov. 22 - 1869**

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
60	2	22	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **General Laborer**

(b) General nature of industry, business, or establishment in which employed (or employer) **Odd Jobs**

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **Ills.**
 (STATE OR COUNTRY)

10. NAME OF FATHER **J. Cannon**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Ills.**
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER **Don't know**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Ills.**
 (STATE OR COUNTRY)

14. INFORMANT **Sarah Cannon**
 (Address) **1116 & Montgomery St.**

15. FILED **1930** **125** **St. Louis**
 REGISTERAR

MEDICAL CERTIFICATE OF DEATH

2 **16. DATE OF DEATH** (MONTH, DAY AND YEAR) **Feb. 14** 19**30**

17. I HEREBY CERTIFY, That I attended deceased **on** **Feb. 14**, 19**30**, to **12:30** p.m., and that I last saw him alive on **Feb. 14**, 19**30**, and that death occurred, on the date stated above at **12:30** p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
16.2 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) **Semility** (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED **Ills.**
 IF NOT AT PLACE OF DEATH.

8 **DID AN OPERATION PRECEDE DEATH?** DATE OF **Feb 15 1930**
 WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS
 (Signed) **Allen H. Roe M.D.**
Feb 15 1930 (Address) **1460 St. Louis**

*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 **Oakwood Cem. altos Ills.** **DATE OF BURIAL** **Feb. 17 1930**

20. UNDERTAKER **1417**
Wey Leidner Mud Co St. Market

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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PARENTS

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