

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

Do not use this space.

11592

M. B.—Every item of information 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.

83-0-28

MAY 22 1930

1. PLACE OF DEATH
 County Ashe Co. N.C. Registration District No. 26
 Township Salt River Primary Registration District No. 9002
 City Atglen (No. 5034) St. _____ Ward _____

2. FULL NAME J. N. Cannon
 (a) Residence No. R.F.D. #6 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) Married

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF Kitty B. Cannon

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar. 7, 1847

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, _____ hrs. or _____ min.
<u>82</u>	<u>11</u>	<u>26</u>		

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Retired Merchant
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Rich County
 (STATE OR COUNTRY) Ill.

10. NAME OF FATHER John Cannon

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) Unknown

12. MAIDEN NAME OF MOTHER Julia Stallard

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) Unknown

14. INFORMANT Kittie B. Cannon
 (Address) Mexico Mo R.F.D. #6

15. FILED Filed 6th 1930 Ina S. Milligan REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 5 1930

17. I HEREBY CERTIFY That I attended deceased from February 1929 to Mar. 5 1930 that I last saw him alive on March 30 1930, and that death occurred, on the date stated above, at 8:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Salvolar heart disease
92A
1065
Switzigean (duration) _____ yrs. _____ mos. _____ ds.
Chronic Bronchitis Arteriosclerosis
 CONTRIBUTORY (SECONDARY) 30 or 40 years (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
 NOT AT PLACE OF DEATH.
 IN AN OPERABLE PREDECEASED DATE OF _____
 WAS THERE AN ATTEST?
 WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) D. H. Berry M. D.
 _____, 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 Elwood, Mexico, Mo. DATE OF BURIAL April 6 1930

20. UNDERTAKER H. A. Paul & Son ADDRESS Mexico Mo.

PHYSICIAN'S STATE BOARD
OF CALIFORNIA

1911
100

1911
100

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

ALL INFORMATION CALLED
 FOR MUST BE WRITTEN ON
 THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Madison
 Township Ball River
 City Ball River (No.)

Registration District No. 26
 Primary Registration District No. 5034

File No.
 Registered No. 51
 St. Ward

2. FULL NAME

J. N. Cannon

(a) Residence. No. 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 7-1847

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
83 0 28

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
 (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)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14.

INFORMANT
 (Address)

15.

FILED Apr 15 1930 Era S Milligan
 REGISTER

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 5 1930

17. I HEREBY CERTIFY, That I attended deceased from to , 1930
 that I last saw him alive on , 1930, and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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) , M. D.
 , 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

20. UNDERTAKER ADDRESS

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

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