

No. 2  
FILED  
X35897

MAY 6 1943

Registration District No. 154

Primary Registration District No. 5575

Registrar's No. 22

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City Rural Washington  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
8039 Michigan Avenue  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether years, months or days)

In this community 21 Years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")

(d) Street No 8039 Michigan Avenue  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mr. Hughlet Calhoun Cannon

3. (b) If veteran, name war None

3. (c) Social Security No. 487-07-6669

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Thelma Cannon

6. (c) Age of husband or wife if alive 34 years

7. Birth date of deceased February 22 1902  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>41</u>	<u>1</u>	<u>24</u>	<u>hr. min.</u>

9. Birthplace Texas  
(City, town, or county) (State or foreign country)

10. Usual occupation Instructor

11. Industry or business Nat'l School of Aeronautics

MOTHER FATHER

12. Name F. M. Cannon

13. Birthplace Springfield Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Lenier

15. Birthplace Texas  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Thelma Cannon

(b) Address 8039 Michigan Avenue

17. (a) Burial (b) Date thereof April 19 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director [Signature]

(b) Address 1401 Brush Creek Blvd

19. (a) 4-19-43 (b) [Signature]  
(Date received local registration) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr. day 15  
year 1943 hour 7:15 minute P. M.

21. I hereby certify that I attended the deceased from Apr. 9 1943 to Apr. 15 1943  
that I last saw him alive on Apr. 11 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Deletation Cardiac

Due to Myocardial insufficiency  
Recurrent Erysipelas

Due to Asphyxiation

Other conditions 11:2  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury 0

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address 805 E. Pasteur Date signed 4/15/43

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

221

*Casson*

*(Handwritten) [unclear]*

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No. ....

working under my personal supervision.

Signed *R. C. Newcomer Jr.*

Licensed Embalmer No. *40430*

P. O. Address *R. C. Mo.*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. 154

Primary Registration District No. 0570-

Registrar's No. 27

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Rural Washington  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution;  
8039 Michigan, Mo.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.....  
(Specify whether  
In this community.....  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson  
(c) City or town Rural Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 8039 Michigan  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME Hughlet C. Cannon

3. (b) If veteran, name war..... 3. (c) Social Security No. ....

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased Mar - 27  
(Month) (Day) (Year)

8. AGE: Years 61 Months 10 Days 18 If less than one day..... min.

9. Birthplace..... (City, town, or county) (State or foreign country) Mo.

10. Usual occupation.....

11. Industry of business.....

MOTHER FATHER { 12. Name.....  
13. Birthplace..... (City, town, or county) (State or foreign country)  
14. Maiden name.....  
15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a) (Burial, cremation, or removal) (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar Year 1943 hour..... minute..... M.

21. I hereby certify that I attended the deceased from.....  
that I last saw him..... alive on....., 19.....  
and that death occurred on the date and hour stated above.  
Immediate cause of death.....

Duration

Due to.....

Due to.....

Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations.....

Of autopsy.....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur?..... (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?.....

While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

S-14486