

S. No. 2
M-2-43
7-5-17-39
X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40229**

FILED JAN 11 1945

Registration District No. **149**

Primary Registration District No. **1002**

Registrar's No. **5291**

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

1. PLACE OF DEATH: **Jackson**

(a) County **Jackson**

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

(c) Name of hospital or institution **K.C. General Hospital No. 2**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **5 days**
(Specify whether in this community years, months or days) **5 days**

2. USUAL RESIDENCE OF DECEASED: **Jackson**

(a) State **Missouri** (b) County **Jackson**

(c) City or town **Warrensburg, Missouri**
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

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

3. (a) PRINT FULL NAME **Emma Louise McCannon**

3. (b) If veteran, name war **no**

3. (c) Social Security No. **none**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **25th**
year **1944** hour **10** minute **25 P.** M.

21. I hereby certify that I attended the deceased from **12-19-44**, 19____ to **12-25-44**, 19____
that I last saw him **or** alive on **12-25-44**, 19____
and that death occurred on the date and hour stated above.

4. Sex **Female** 5. Color of race **Wht**

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

6. (b) Name of husband or wife **Russell H. McCannon** alive _____ years

6. (c) Age of husband or wife if **unk**

7. Birth date of deceased **May 4 1922**
(Month) (Day) (Year)

Immediate cause of death **Bulbar Poliomyelitis**

Due to _____

Due to **36**

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

8. AGE: Years **22** Months **7** Days **5** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Housewife**

Major findings: Of operations _____

Of autopsy **None**

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

11. Industry or business _____

MOTHER { 12. Name **John E. Lamont**

13. Birthplace **Neuss Co. Mo**
(City, town, or county) (State or foreign country)

14. Maiden name **Boona Reynolds**

15. Birthplace **Boona Co. Mo**
(City, town, or county) (State or foreign country)

16. (a) Informant **Russell H. McCannon**

(b) Address **Warrensburg Mo**

17. (a) **removal** (b) Date thereof **12-26-44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Warrensburg Mo**

18. (a) Signature of funeral director **Dimmons A. Stone**

(b) Address **1404 So 37 R E 100**

19. (a) **12-27-44** (b) **D. E. Brown**
(Date received local registry) (Registrar's signature)

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? _____

23. Signature **A. E. Usher** (Specify type of place) _____
(M. D. of _____) (a) Means of injury _____

Address **Med. Dir. K.C. Gen. Hospital** (M. D. of _____) **12-26-44**
Date signed

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, only.....

....., Registered Apprentice No.
working under my personal supervision.

Signed H. Simmons.....

Licensed Embalmer No. 3903.....

P. O. Address H C Ks.....

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.