

FILED MAY 27 1947

Registration District No. **114**

Primary Registration District No. **4186**

Registrar's No. **12**

1. PLACE OF DEATH:

(a) County **FRANKLIN**
(b) City or town **SULLIVAN**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
AT HOME
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ~~2 1/2 weeks~~
all her life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO.** (b) County **FRANKLIN**
(c) City or town **SULLIVAN, MO.**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **CLARA I. CANNON**

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

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **MARRIED**
6. (b) Name of husband or wife **JOHN CANNON** 6. (c) Age of husband or wife if alive **87** years
7. Birth date of deceased **JULY 2 1865**
(Month) (Day) (Year)

8. AGE: Years **81** Months **10** Days **3** If less than one day hr. min.

9. Birthplace **SULLIVAN MO.**
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSEWIFE**

11. Industry or business **HOME**

MOTHER FATHER { 12. Name **HENRY BENSON**
13. Birthplace **SULLIVAN MO.**
(City, town, or county) (State or foreign country)
14. Maiden name **MIRNA BLEDSOE**
15. Birthplace **SULLIVAN MO.**
(City, town, or county) (State or foreign country)

16. (a) Informant **MYRTLE AVIS**

(b) Address **1254 LACROIX ST. RD. PENNINGTON Hts.**

17. (a) **Burial** (b) Date there **MAY 7 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **BURIAL 1004 Sullivan**

18. (a) Signature of funeral director **P. J. Williams**

(b) Address **817 N. WALK SULLIVAN MO.**

19. (a) **MAY 7 - 1947** (b) **C. J. ...**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **MAY** day **5**, year **1947** hour **9:20** minute **A.M.**

21. I hereby certify that I attended the deceased from **April 7,** 19**47** to **May 5,** 19**47**
that I last saw her alive on **MAY 5**, 19**47**
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Myocarditis**
Arteriosclerosis

Other conditions (Include pregnancy within 3 months of death)
MI 3rd

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) (c) Means of injury _____

23. Signature **John J. de la Torre** (M. D. or other) **M.D.**
Address **Sullivan, MO.** Date signed **5/8/47**

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

16
4
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RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 5-26-47

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 *John W. Olson*
Licensed Embalmer No. *4344*

P. O. Address *347 N. CLARK, SUWANNA*

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.