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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 8 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 37953

Registration District No. 318 Primary Registration District No. 1005 Registrar's No. 10416

1. PLACE OF DEATH:

(a) County

(b) City or town ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
ST. LOUIS MATERNITY HOSPITAL 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community 12 HOURS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County 000

(c) City or town ST. LOUIS 17
(If outside city or town limits, write "RURAL") 7

(d) Street No. 4532 A KENNERLY 0
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No) 11

If yes, name country

3. (a) PRINT FULL NAME INFANT MALE CANN

3. (b) If veteran, name war NO

3. (c) Social Security No.

4. Sex MALE 2

5. Color or race NEGRO

6. (a) Single, widowed, married, divorced SINGLE 0

6. (b) Name of husband or wife

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

7. Birth date of deceased NOVEMBER (Month) 18 (Day) 48 (Year)

8. AGE: Years | Months | Days | If less than one day 12 hr. 5 min.

9. Birthplace ST. LOUIS (City, town, or county) MISSOURI (State or foreign country) 0

10. Usual occupation NONE

11. Industry or business

FATHER
12. Name CLEMMIE ELMER CANN 1
13. Birthplace CROSSETT (City, town, or county) ARKANSAS (State or foreign country)

MOTHER
14. Maiden name EMALUISE CECELIA WEDDINGTON
15. Birthplace MC GEE (City, town, or county) ARKANSAS (State or foreign country) 1

16. (a) Informant ST. LOUIS MATERNITY HOSPITAL
(b) Address 630 SO. KINGSHIGHWAY

17. (a) Anatomical Board (Burial, cremation, or removal) (b) Date thereof NOV 30 1948 (Month) (Day) (Year)
(c) Place: burial or cremation Anatomical Board

18. (a) Signature of funeral director Rowland Mort Service
(b) Address 4104 Manchester Ave

19. (a) NOV 30 1948 (Date received local registrar) (b) J. B. Lasater (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOVEMBER day 19
year 1948 hour 1 minute 45A. M.

21. I hereby certify that I attended the deceased from NOVEMBER 18, 1948 to NOVEMBER 19, 1948
that I last saw him alive on NOVEMBER 19, 1948
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Intracranial hemorrhage	12 hrs.
Atelectasis: Prematurity	12 hrs.
Due to Prematurity & birth trauma	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

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Major findings:
Of operations
Of autopsy Intracranial hemorrhage Pulmonary atelectasis Prematurity

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?
(Specify type of place)
While at work? (e) Means of injury 0

23. Signature John L Carter (M. D. or other) M.D.
Address City Hosp Date signed 11/19

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

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.