

11586

State File No.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAY 5 1954

No. 300
10-48

BIRTH NO. _____		REG. DIST. NO. <u>87</u>		PRIMARY REG. DIST. NO. <u>4565</u>		Registrar's No. <u>7</u>	
1. PLACE OF DEATH a. COUNTY <u>CRAWFORD</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>CRAWFORD</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>SULLIVAN BOOKE</u>		c. LENGTH OF STAY (In this place) <u>6 YRS</u>		c. CITY OR TOWN <u>SULLIVAN</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Home 455 S Park</u>				e. STREET ADDRESS (If rural, give location) <u>4555 PARK 0281</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>GERMAN</u>		b. (Middle) <u>HUDSON</u>		c. (Last) <u>CANNON</u>	
4. DATE OF DEATH		(Month) <u>APRIL</u>		(Day) <u>27</u>		(Year) <u>1954</u>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>JAN 30, 1870</u>	
9. AGE (In years last birthday) <u>84</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u>27</u>		IF UNDER 24 HRS. Hours <u></u> Mins. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BLACKSMITH & FARMING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (City and State or Foreign Country) <u>TENNESSEE TENNESSEE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>WILLIAM CANNON</u>		13b. MOTHER'S MAIDEN NAME <u>ELIZABETH FOSTER</u>		14. NAME OF HUSBAND OR WIFE <u>ELIZABETH CANNON</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>499-18-2241</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>MARY KENDRICK SULLIVAN</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerotic heart disease</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Fracture of neck of femur 6 wks.</u>				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>4200 F</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR			
22. I hereby certify that I attended the deceased from <u>Feb</u> , 1954, to <u>4-27</u> , 1954, that I last saw the deceased alive on <u>4-27</u> , 1954, and that death occurred at <u>3:10</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Ronald H. Scott, D.O.</u>		23b. ADDRESS <u>Sullivan, Mo.</u>		23c. DATE SIGNED <u>4-29-54</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>5/1/54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>N.O.O.F. CEMETERY</u>		24d. LOCATION (City, town, or county) (State) <u>SULLIVAN, MO.</u>	
DATE REC'D BY LOCAL REG. <u>4-29-1954</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u> 750		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Am. Eaton Sullivan, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADEING BLACK INK—MAKE A PERMANENT RECORD

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, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *J.A. Hemphill*.....

Licensed Embalmer No. *4772*

P. O. Address *Sullivan*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.