

THE DIVISION OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

58-023189  
STATE FILE NUMBER  
318 Primary Registration District No. 1003 Registrar's No. 4688

XC-1207 815  
SL 16527  
FILED JUN 16 1958

300  
1-57  
0

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>915 N. GRAND, ST. LOUIS, MO.</b>		c. CITY OR TOWN <b>NORMANDY</b> <b>4170</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VET. ADM. HOSPITAL</b>		d. STREET ADDRESS (If outside, give location) <b>5318 GLADSTONE</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARTIN</b> Middle <b>CANNON</b> Last		4. DATE OF DEATH Month <b>APRIL</b> Day <b>30</b> Year <b>1958</b>	
5. SEX <b>MALE</b> 0	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/18/95</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>62</b> IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
11. BIRTHPLACE (City and state or country) <b>ST. LOUIS, MO.</b> 0		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>JAMES CANNON</b>		13b. MOTHER'S MAIDEN NAME <b>CATHERINE FERRY</b>	
14. NAME OF HUSBAND OR WIFE - - - - -		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give dates of service) <b>YES</b> <b>WW-1</b>	
16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>VA HOSP. RECORDS, ST. LOUIS, MO.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHO PNEUMONIA</b> <b>CHRONIC BRONCHITIS</b> <b>502.1</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) - - - - - DUE TO (c) - - - - - PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). <b>ARTERIOSCLEROTIC HEART DISEASE</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 WEEK</b> <b>30 YEARS</b> -
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> /		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <b>NONE</b> <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <b>4/21/58</b> to <b>4/30/58</b> and last saw <del>her</del> him alive on <b>4/30/58</b> Death occurred at <b>6:00 A.M.</b> (on the date stated above; and to the best of my knowledge, from the causes stated.)			
22a. SIGNATURE <b>J. D. Callahan, M.D.</b>		22b. ADDRESS <b>VAH, ST. LOUIS, MO.</b>	
22c. DATE SIGNED <b>4/30/58</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	
23b. DATE <b>May 2-1958</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>	
23d. LOCATION (City, town, or county) <b>St. Louis Co., Mo.</b>		(State)	
24. FUNERAL DIRECTOR <b>Buchholz - 5967 W. Florissant</b>		25. DATE RECD. BY LOCAL REG. <b>MAY 1 '58</b>	
26. REGISTRAR'S SIGNATURE <b>J. Carl Smith MO</b> <b>50</b>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

Doctor, coroner, etc., must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *Arthur H. Buchholz* .....

Licensed Embalmer No. *4551* .....

P. O. Address *St. Louis* .....

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.