

pt. Health,
, & Welfare
S. Public
lth Service

FILED SEP 29 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-034072

STATE FILE NUMBER

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

8707

S. 300
v. 1-57
0

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>St. Louis</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>University City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bethesda General Hosp</u>		Length of stay in 1b <u>11 yrs 27</u>	d. STREET ADDRESS (If outside, give location) <u>7275 Kingsbury</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>CORA</u> Middle <u>CAMERON</u> Last <u>CANN</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>6</u> Year <u>1958</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 26, 1867</u>		9. AGE (In years, IF UNDER 1 YEAR last birthday) Months Days Hours Min. <u>91 yrs</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Nevada, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>E. F. Cameron</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Sullards</u>		14. NAME OF HUSBAND OR WIFE <u>William A. Cann</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No None</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Mr. Frank C. Cann 7554 Hoover (17)</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u>					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>generalized arteriosclerosis</u>			420.0 F
		DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition shown in PART I (a) <u>fracture femur neck right (big)</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Fall at Home</u>			
20c. TIME OF INJURY? Hour Month, Day, Year a.m. p.m. <u>7-27-58</u>		<u>D.R. Page Sr. Deacon, Deputy Cann 9/9/58</u>			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. CITY, TOWN, OR LOCATION <u>University City</u> COUNTY <u>Mo.</u> STATE <u>Mo.</u>	
21. I attended the deceased from <u>7-27-58</u> to <u>9-6-58</u> and last saw her alive on <u>9-6-58</u> Death occurred at <u>9:30 Pm</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Ronald A. Barst mo</u> (Degree or title) <u>0</u>			22b. ADDRESS <u>16 Hampton Village</u>		22c. DATE SIGNED <u>9/8/1958</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>Sept. 9, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u>
24. FUNERAL DIRECTOR <u>Alexander & Sons 6175 Delmar</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>SEP 9 '58</u>		26. REGISTRAR'S SIGNATURE <u>Charles Smith MO</u> <u>msb</u>	

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

Student
Signature of Student Embalmer

Signed *Jos. E. McCulloch*

Licensed Embalmer No. *2462*

P. O. Address *615 22nd*

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.