

UNIFORM DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-027532

FILED VS JUL 26 1960

STATE FILE NUMBER

Registration District No. 179 Primary Registration District No. 5673 Registrar's No. 96

ENDED

1. PLACE OF DEATH a. COUNTY <b>Lincoln</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Lincoln</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Monroe</b>		Length of stay in 1b <b>40 yr.</b>		c. CITY OR TOWN		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>4 Mi. west of Winfield MO.</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>4 Mi. West of Winfield MO.</b>			Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First: <b>JAMES</b> Middle: <b>FLOYD</b> Last: <b>CANNON</b>				4. DATE OF DEATH <b>July 18, 1960</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>1/17, 1883</b>	9. AGE (last birthday) <b>77</b>	IF UNDER 1 YEAR Months <b>6</b> Days <b>1</b>	IF UNDER 24 HR Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (City and state or country) <b>Foley Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>Macus Cannon</b>			13b. MOTHER'S MAIDEN NAME <b>Delia Foxwell</b>		14. NAME OF HUSBAND OR WIFE <b>Elsie Cannon</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>None</b>			16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT <b>Ralph Cannon</b>		Address <b>Winfield 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>Coronary Thrombosis</b> <b>atherosclerosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>1 Hour</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input 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.)					
20c. TIME OF INJURY Hour <b>11</b> a.m. Month, Day, Year								
20d. INJURY OCCURRED WHILE AT WORK <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.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE	
21. I attended the deceased from <b>May 1 - 60</b> to <b>July 18/60</b> and last saw her/him alive on <b>July 18/60</b> Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <b>J. Lee Seck</b> (Degree or title)				22b. ADDRESS <b>Tracy Mo.</b>		22c. DATE SIGNED <b>July 19/60</b> (Date)		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>July 21, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New Salem Cemetery</b>		23d. LOCATION (City, town, or county) <b>Lincoln County, Mo.</b>			
24. FUNERAL DIRECTOR <b>Dw. McGee Tracy Mo.</b> ADDRESS				25. DATE RECD. BY LOCAL REG. <b>7-20-1960</b>	26. REGISTRAR'S SIGNATURE <b>Charlotte Seck</b>			

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 23 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed D. W. McElroy  
Licensed Embalmer No. 3586

P. O. Address Froy Me

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.