

S. No. 300
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FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **41337**
Registrar's No. **10618**

FILED DEC 23 1948
Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
(a) County None
(b) City or town Saint Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 4441 West Belle Place
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 60 years years, months or days

3. (a) PRINT FULL NAME CANNON, Albert
3. (b) If veteran, name war _____ 3. (c) Social Security No. not known

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Martha 6. (c) Age of husband or wife if alive dec'd years
7. Birth date of deceased unavailable (Month) (Day) (Year) abt. 1875

8. AGE: Years about 73 Months - Days - If less than one day hr. _____ min. _____

9. Birthplace Unavailable Tennessee (City, town, or county) (State or foreign country)

10. Usual occupation Janitor

11. Industry or business _____

MOTHER FATHER { 12. Name Albert Cannon
13. Birthplace Unavailable Tennessee (City, town, or county) (State or foreign country)
14. Maiden name Louise Unavailable
15. Birthplace Unavailable (City, town, or county) (State or foreign country)

16. (a) Informant Lillian Wilson
(b) Address Robertson, Missouri

17. (a) Burial (b) Date thereof 12/9/48 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cemetery

18. (a) Signature of funeral director: Charles J. Gates
(b) Address 4107 Finney Avenue

19. (a) DEC 7 1948 (b) J.B. Lanater (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County None
(c) City or town Saint Louis (If outside city or town limits, write "RURAL")
(d) Street No. 4441 West Belle Pl (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December, day 5th, year 1948 hour 6:30 minute 4 A.M.
21. I hereby certify that I attended the deceased from July, 1948, to Dec 5th, 1948

that I last saw him alive on December 5th, 1948, and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive Cardiac Disease Duration _____

Due to _____
Due to _____
Other conditions: _____ (Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

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? _____

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

23. Signature R. H. Vassell (M. D. or other)
Address 4270a W. Finney Ave Date signed _____

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.....

Thomas Bates

Licensed Embalmer No. *4259*

P. O. Address *4107 7*

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.