

FILED JUL 28 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23258**

BIRTH NO. _____ REG. DIST. NO. 150 PRIMARY REG. DIST. NO. 5573 Registrar's No. 138

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give town or township) Grain Valley		c. CITY OR TOWN Grain Valley	d. Is Residence within limits of a city or incorporated town? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
c. LENGTH OF STAY (in this place) 80yrs		e. STREET ADDRESS (If rural, give location) City 2000	
d. FULL NAME OF HOSPITAL OR INSTITUTION City			

3. NAME OF DECEASED (Type or Print)	a. (First) Marshall	b. (Middle) Demot	c. (Last) Cannon	4. DATE OF DEATH (Month) (Day) (Year) July 14 1954
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5. SEX Ma	6. COLOR OR RACE Wh	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH May 4 1872	9. AGE (In years last birthday) 82	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Grain Valley Mo	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME James H Cannon	13b. MOTHER'S MAIDEN NAME Mary Dyer	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Mrs Addie Minter	ADDRESS Grain Valley Mo
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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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 1 hr
	ANTECEDENT CAUSES Morbidity 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. _____		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from 1947, 1954, to 7-14, 1954 that I last saw the deceased alive on 7-11, 1954 and that death occurred at 6:00 p.m., from the causes and on the date stated above.

23a. SIGNATURE W. W. Williams (Degree or title) MD	23b. ADDRESS Oak Grove No 7	23c. DATE SIGNED 7-15-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE July 17-54	24c. NAME OF CEMETERY OR CREMATORY Blue Springs	24d. LOCATION (City, town, or county) (State) Blue Springs Mo
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DATE REC'D BY LOCAL REG. 7-19-1954	REGISTRAR'S SIGNATURE D. B. Lanyon	25. FUNERAL DIRECTOR'S SIGNATURE Webb Funeral Home	ADDRESS Blue Springs Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1901 9 1 1007

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..... *Rob Webb*

Licensed Embalmer No. *235*

P. O. Address *Blum spr*

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.