

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-012281

STATE FILE NUMBER

FILED MAY 4 1959

Registration District No. 38

Primary Registration District No. 3006

Registrar's No. 191

5. 300  
1-57

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>	
b. CITY OR TOWN <u>Columbia</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Marceline</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>Univ. of Mo. Med. Center</u>	Length of stay in lb <u>210 hr</u>	d. STREET ADDRESS (If outside, give location) <u>315 E. HOUSE</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Walter</u> Last <u>Cannon</u>			4. DATE OF DEATH Month <u>April</u> Day <u>26</u> Year <u>1959</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 14, 1891</u>		9. AGE (In years last birthday) <u>68</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coal miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal mining</u>		11. BIRTHPLACE (City and state or country) <u>Marceline Mo</u>		
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>						

13a. FATHER'S NAME <u>Patrick Cannon</u>		13b. MOTHER'S M maiden NAME <u>Savina Jane Weese</u>		14. NAME OF HUSBAND OR WIFE <u>Samara Cannon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Hospital Record</u> Address <u>Columbia, Mo</u> <u>Univ. Hospital</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>Pulmonary Edema</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>
DUE TO (b) <u>Carcinoma of brain</u>			<u>Unknown</u>
DUE TO (c) <u>Carcinoma of Stomach</u>			<u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____			19. WAS AUTOPSY PERFORMED? 1 YES <input checked="" type="checkbox"/> NO <input 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 _____ a.m. _____ p.m. _____	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.) _____		20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____	

21. I attended the deceased from 4-10-59 to 4/26/59 and last saw ~~him~~ her alive on 4/26/59  
Death occurred at 2:30 AM on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Paul B Spahr, M.D.</u> (Degree or title)		22b. ADDRESS <u>Univ. Hospital, Columbia, Mo.</u>		22c. DATE SIGNED <u>4/24/59</u>	
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>4-26-59</u>		23c. NAME OF CEMETERY OR CREMATORY _____		23d. LOCATION (City, town, or county) _____ (State) <u>Mo</u>	
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24. FUNERAL DIRECTOR <u>Parke Funeral Service</u> ADDRESS <u>Columbia</u>		25. DATE RECD. BY LOCAL REG. <u>April 26, 59</u>		26. REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>	
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(Licensed Embalmer's Statement on Reverse Side)

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

9004 MAY 6 1959

MAY 5 1959  
MAY 7 1959

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 *Douglas P. Garma* .....

Licensed Embalmer No. *5037* .....

P. O. Address *Columbia* .....

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.