

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

6196

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003** File No. **1300**
 City **St. Louis** (No. **City Hospital**) St. _____ Ward _____
14274
 2. FULL NAME **Theresa Cunningham**
 (a) Residence. No. **2413 Locust St.** Ward **21**.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred **21** yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **Female**
 4. COLOR OR RACE **White**
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Married**
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Jan 10 1867**
 7. AGE YEARS MONTHS Days If LESS than 1 day, ____ hrs. or ____ min.
60 | **9** | **26**
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work **Housewife**
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Feb 5 1927**
 I HEREBY CERTIFY That I attended deceased from **Jan 27 1927** to **Feb 5 1927**
 that I last saw him alive on **Jan 27 1927**, and that death occurred, on the date stated above, at **452**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia
 15. _____ (duration) yrs. mos. da.
 CONTRIBUTORY (SECONDARY) **10/10**
 _____ (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH? _____
 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS?
7/5 (Signed) **Theresa Cunningham**, M. D.
 (Address) **City Hospital**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
 19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Georgetown** DATE OF BURIAL **Feb 8 1927**
 ADDRESS _____

20. UNDERTAKER **W. P. Adams** ADDRESS **1039 N. Grand**

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Missouri**
 10. NAME OF FATHER **Ray - John**
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Missouri**
 12. MAIDEN NAME OF MOTHER **Not Known**
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Missouri**
 14. INFORMANT **Anna** (Address) **City Hospital**
 15. FILED **Feb - 11 1927** Max G. Starkeoff Registrar

PARENTS

Livingston

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No. 791 File No.....
 Township..... Primary Registration District No. 1003 Registered No. 1300
 City St. Louis (No.) St. (Word)

2. FULL NAME

(a) Residence, No. St. Ward.....
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX D 4. COLOR OR RACE A 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED May 6 1927 Starkoff

MEDICAL CERTIFICATE OF DEATH

15. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 5 1927
 17.

I HEREBY CERTIFY, That I attended deceased from to 19..... that I last saw h..... after which death occurred, on the date stated above; at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (duration)..... yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D. , 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

Feb. 8 1927

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

SUPPLEMENTARY

5-6126