

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

Do not use this space.

13111

1. PLACE OF DEATH

County.....
Towship.....
City *St. Louis Mo.* (No.....) *Sanitarium*

Registration District No. **791**
Primary Registration District No. **1003**

File No.....
Registered No. *13410* St..... Ward.....

2. FULL NAME

Alonzo Cunningham
(a) Residence. No. *237 1/2* *Steterb* St. *13* Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred *6* yrs. *7* mos. *da.* How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>Male</i>	4. COLOR OR RACE <i>white</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Single</i>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Jan. 29. 1860*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<i>67</i>	<i>2</i>	<i>10</i>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Cabinet Maker - Carpenter*
(b) General nature of industry, business, or establishment in which employed (or employer) *Unknown*
(c) Name of employer

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

PARENTS	10. NAME OF FATHER <i>Unknown</i>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <i>Indiana</i>
	12. MAIDEN NAME OF MOTHER <i>Unknown</i>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <i>Indiana</i>

14. INFORMANT *K. Shumell*
(Address) *City saw*

15. FILED *APR -3 1927* *Mar 6 Star coff*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *4-7-1927*

17. I HEREBY CERTIFY, That I attended deceased from *3-21-1927* to *4-7-1927*, that I last saw him alive on *4-7-1927*, and that death occurred, on the date stated above, at *3:40 p.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia

108 *101a*

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

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) *K. Shumell*, M. D.

4-7-1927 (Address) *City saw*

*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 DATE OF BURIAL

St. Matthews Cem. City 9 19 27

20. UNDERTAKER ADDRESS *Geo. L. Plaitoch 37 6 6*

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

