

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

Do not use this space.

35948

Information should be carefully supplied. AGE should be state in terms, so that it may be properly classified. Exact state should state by important.

1928
 JAN 17

1. PLACE OF DEATH
 County Barton Registration District No. 61
 Township Alexander Primary Registration District No. 5098
 City (No.) St. Ward (If nonresident give city or town and State)
 2. FULL NAME (Unnamed) Cunningham
 (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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) A -

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 2

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

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work none
 (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) MO

10. NAME OF FATHER Ab Cunningham

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

12. MAIDEN NAME OF MOTHER Cora Williams

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

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 27 1927

17. I HEREBY CERTIFY, That I attended deceased from Dec 23, 1927, to Dec 27, 1927 that I last saw h. alive on Dec 23, 1927, and that death occurred, on the date stated above, at 2 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
No Vitality - barely breathed during the day of living (duration) - yrs. - mos. 1 da.

CONTRIBUTORY (SECONDARY) 158 160 (duration) - yrs. - mos. - da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH,
 19. DID AN OPERATION PRECEDE DEATH, DATE OF
 WAS THERE AN AUTOPSY,
 WHAT TEST CONFIRMED DIAGNOSIS,
 (Signed) James H. Logan M. D.
1224, 1927 (address) Wasson MO

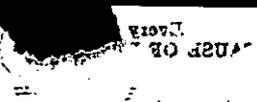
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Fairfield MO DATE OF BURIAL Dec 27 1927

20. UNDERTAKER none ADDRESS

14. INFORMANT Ab Cunningham
 (Address) Fairfield MO

15. FILED 1/30 27 Jan A Logan
 REGISTRAR



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**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 Benton Registration District No. 6-1 File No.
 Township Alexander Primary Registration District No. 3-0-98 Registered No. 21
 City (No.) St. Ward

2. FULL NAME unnamed Cunningham

(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

MEDICAL CERTIFICATE OF DEATH

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

15. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 24 1927

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

17. I HEREBY CERTIFY That I attended deceased from
 that I last saw h..... alive on 19....., and that death occurred, on the date stated above, at.....
 THE CAUSE OF DEATH WAS AS FOLLOWS:

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 23 1927

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

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

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

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)

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

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)

*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.

14. INFORMANT (Address)

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

FILED 12/31 27 Jas. A. Logan REGISTRAR

20. UNDERTAKER ADDRESS

RECEIVED A FEE FOR CERTIFICATES UNTIL THEY ARE REGISTERED
 C. of Inform. in terms, so that it may be properly class. 1. Exact street, name of OCCUPATION is for
 PHYSICIANS if important. BY LAW

SUPPLEMENTARY

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