

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

Do not use this space.

24835
5247

1. PLACE OF DEATH

County Jackson Registration District No. 1002 File No. _____
 Township Blue Primary Registration District No. _____ Registered No. _____
 City Leeds, Mo. (No. Tuberculosis Hosp.) St. _____ Ward _____

2. FULL NAME

Cunningham Edith M.
 (a) Residence. No. 3525 Smart St. 9 Ward. _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 2 yrs. mos. 9 da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan-18-1907

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>22</u>	<u>6</u>	<u>9</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School Teacher
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

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

PARENTS

10. NAME OF FATHER Maxey Cunningham

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

12. MAIDEN NAME OF MOTHER Rachel Gibson

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

14. INFORMANT K. J. Tuberculosis Hosp
 (Address) Leeds, Mo.

15. FILED 7/28/29 M. M. Crowe
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 27 1929

17. I HEREBY CERTIFY, That I attended deceased from July 27, 1929, to July 27, 1929, that I last saw her alive on July 27, 1929, and that death occurred, on the date stated above, at 2019 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

76A Pulmonary tuberculosis
 (duration) _____ yrs. _____ mos. _____ da.
 CONTRIBUTORY (SECONDARY) 31
 (duration) _____ yrs. _____ mos. _____ da.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Microscopic findings
 (Signed) Hubert L. Mandy, M. D.

7/27, 1929 (Address) 818 Mutual Apts, Lees

*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 Marshall #110 DATE OF BURIAL 7/29 1929

20. UNDERTAKER W. Mast ADDRESS 1915 East 15

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.

WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

2-15

