

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

Do not use this space.

5122

File No. _____
Registered No. 780
St. _____ Ward _____

1. PLACE OF DEATH

County Jackson Registration District No. 399
Township Kaw Primary Registration District No. 1002
City Kennett (lastly known) No. Research Hts St. _____ Ward _____

2. FULL NAME Mary Agnes Cunningham

(a) Residence. No. 2220 Holmes St. 3 Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. mos. 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 Single

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 27-1882

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
47 7 28

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work okansas
(b) General nature of industry, business, or establishment in which employed (or employer) Research Hts
(c) Name of employer

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

10. NAME OF FATHER Joseph Cunningham

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

12. MAIDEN NAME OF MOTHER Mary Howard

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

14. INFORMANT Mrs Peter Larson
(Address) Kennett - Wis

15. FILED 7/20 30 19 30 M. M. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 19 19 30

17. I HEREBY CERTIFY, That I attended deceased from Feb 11, 1930, to Feb 19, 1930, that I last saw h. a. alive on Feb 19, 1930, and that death occurred, on the date stated above, at 8:00 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia
R. lung lobe upper
lower lobe free
(duration) yrs. mos. 8 da.

18. CONTRIBUTORY Asplenic anemia debility
(SECONDARY)
(duration) yrs. mos. da.

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

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical signs
(Signed) Ludwig Melnik M. D.
1070, 1930 (Address) 800 Cedar Bl Berg

*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 Meredah Wis DATE OF BURIAL Feb 21 19 30

20. UNDERTAKER John W Wagner ADDRESS 1409 Grand Ave

Ha 4479

130/10.3/34 PML

**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. 399 File No.
 Township..... Primary Registration District No. 1002 Registered No. 780
 City K City (No.) St. (Ward)

2. FULL NAME

Mrs. Agnes 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

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

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)

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 2/20/30 M. M. Brown REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/19/30

17. I HEREBY CERTIFY, That I attended deceased from 19..... to 19..... (that I last saw him after on 19....., and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia, Lobar
 (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) 101W
 (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.

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

20. UNDERTAKER ADDRESS

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

SUPPLEMENTARY