

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.

FEB 27 1934

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

Do not use this space.

868

1. PLACE OF DEATH

County Greene Registration District No. 324 File No. _____
Township Robertson Primary Registration District No. 5-449 Registered No. _____
City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Richard William 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 <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR WIFE OF) <u>Emma MacCunningham</u>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Nov 13 1878</u>				
7. AGE	YEARS <u>55</u>	MONTHS <u>2</u>	DAYS <u>3</u>	IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Farmer</u>			
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.			
	10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ark</u>				
MOTHER	13. NAME <u>W^m Franklin Cunningham</u>			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>N.C.</u>			
	15. MAIDEN NAME <u>Alice Wright</u>			
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo</u>				
17. INFORMANT <u>Mrs R. W. Cunningham</u> (ADDRESS) <u>Springfield Mo R.F.D. 6</u>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Cedar Creek</u> DATE <u>1/18 34</u>				
19. UNDERTAKER <u>W. E. Holman</u> (ADDRESS) <u>Lebanon</u>				
20. FILED <u>Jan 27 1934</u> <u>Mrs. Guy Greenan</u> Registrar.				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1/18 1934

22. I HEREBY CERTIFY, That I attended deceased from Jan 23, 1933, to Jan 17, 1934
I last saw him alive on Jan 17 1934 Death is said to have occurred on the date stated above, at 8:30 a.m.
The principal cause of death and related causes of importance were as follows:
Carcinoma of Prostate Date of onset 1931
Metastasis to cord
in Jan. 1933

Other contributory causes of importance:
None

Name of operation None Date of _____
What test confirmed diagnosis? Paralysis legs Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? No Date of injury _____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. No

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?
If so, specify No
(Signed) W. E. Holman M. D.
(Attending Physician) W. E. Holman

Will 5th Floor Md. City

Mr. King Freeman
W. Willard, Mo