

JAN 13 1936

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

Do not use this space.

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City **St. Louis** (No. **St. Anthony's Hospital**) Registered No. **41766**
St. **11013** Ward.....

2. FULL NAME

Agnes Cunningham
(a) Residence, No. **1720 Missouri** St., **23** Ward. (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 **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) **July 27 1912**
7. AGE YEARS **23** MONTHS **10** DAYS **30** If LESS than 1 day, _____ hrs. or _____ min.
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. **Housework**
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. **at home**
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) **St. Louis Mo**

13. NAME **Peter Cunningham**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ireland**

15. MAIDEN NAME **Bridget Rowley**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ireland**

17. INFORMANT (ADDRESS) **Mrs. B. Cunningham 1730 Missouri**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Culwary** DATE **Dec 28 1935**

19. UNDERTAKER (ADDRESS) **John P. Calins & Bro 2928 No. Grand**

20. FILED **DEC 27 1935** **J. Brebeck** Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Dec 26 1935**

22. I HEREBY CERTIFY, That I attended deceased from **Dec 23 1935**, to **Dec 26 1935**

I last saw him alive on **Dec 25 1935**. Death is said to have occurred on the date stated above, at **12:40** m.

The principal cause of death and related causes of importance were as follows:

Apoplexy due to cerebral hemorrhage 2/24/35

Other contributory causes of importance: **Epilepsy 8/20/25**

Name of operation **none** Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? **no**

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? **no**
If so, specify _____
(Signed) **Edna G. Greenway** M. D.
(Address) **2924 S Grand St**

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.

