

DEC 30 1936

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

Do not use this space.

40203

1. PLACE OF DEATH

County Webster
Township Jackson
City Stair Road (No.)

Registration District No. 499
Primary Registration District No. 6205

File No. _____
Registered No. 12
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs W. M. Cunningham

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

7. AGE YEARS 81 MONTHS _____ DAYS _____ If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer

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) Webster Co. Mo.

13. NAME Hugh Cunningham

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Idaho

15. MAIDEN NAME Amanda Audekell

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Idaho

17. INFORMANT Mrs W. M. Cunningham (ADDRESS) Stair Road

18. BURIAL, CREMATION, OR REMOVAL PLACE Desert View DATE 10-16-36

19. UNDERTAKER H. B. Jones (ADDRESS) Buffalo Mo.

20. FILED W. 25 1936 E. M. Bailes Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-15, 1936

22. I HEREBY CERTIFY, That I attended deceased from 10-10, 1936, to 10-15, 1936.

I last saw him alive on Oct. 15, 1936. Death is said

to have occurred on the date stated above, at 9:45 a.m.

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

Catarrhal Dysentery.

Date of onset

Other contributory causes of importance

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

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? _____

If so, specify _____

(Signed) G. A. Meyer, M. D.

(Address) 540 1/2 E. Com St. Springfield Mo.

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.

