

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

**6062**  
Do not use this space.

REC'D MAR 15 1939

1. PLACE OF DEATH  
 (a) County Callaway 3 Registration District No. 104  
 (b) Township Fulton 1 Primary Registration District No. 3008 Registered No. 54  
 (c) City Fulton (d) Street No. State Hospital St St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred 2 yrs. 1 mos. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME James C. Cunningham  
 (a) Residence, No. Troy, Mo. St.  (If nonresident, give city or town and State)  
 (Usual place of abode if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) D.K.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
approx 82

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc. D.K.  
 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) D.K.

FATHER  
 13. NAME D.K.  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) D.K.

MOTHER  
 15. MAIDEN NAME D.K.  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) D.K.

17. INFORMANT (ADDRESS) State Hosp # 1, records Fulton Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Troy, Mo. DATE Feb 16, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Leah G. Wallace Fulton, Mo.

20. FILED Feb 16, 1939 P. T. Cruise Local Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 15th 1939

22. HEREBY CERTIFY, That I attended deceased from July 7th 1938 to Feb 15th 1939  
 I last saw him alive on Feb 14th 1939. Death is said to have occurred on the date stated above, at 5:50 AM.  
 The principal cause of death and related causes of importance were as follows:  
Arteriosclerosis  
Senility  
Senile Psychosis  
Blindness  
 Date of onset 97

Other contributory causes of importance:  
Senility  
Senile Psychosis  
Blindness

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? None 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) J. R. Burch, M. D.  
 (Address) State Hospital No 1

K. 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.

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**