

22ND JUL 12 1939

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

20397
Do not use this space.
5241

791
1008

1. PLACE OF DEATH

(a) County.....
(b) Township.....
(c) City, St. Louis, Mo.

Registration District No.....
Primary Registration District No.....
(d) Street No. City Hospital No. 1 St.

(e) Length of residence in city or town where death occurred yrs. mos. ds. E3290 5 5 2

(f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Patrick Cunningham

(a) Residence, No. 5102 Cates St. 12

(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE white
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 5-5-1866

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
73 1 1

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.
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) Ireland 5

FATHER 13. NAME Michael Cunningham

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland 5

MOTHER 15. MAIDEN NAME Ann Cunningham

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

17. INFORMANT (ADDRESS) Hosp. Info M. Kent

18. BURIAL, CREMATION, OR REMOVAL PLACE CALVARY DATE 6/12/39

19. FUNERAL DIRECTOR (ADDRESS) Funeral Home of 384 N. 5th St. St. Louis, Mo.

20. FILED JUN 12 1939 J. F. Breder Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6/10/39 19

22. I HEREBY CERTIFY That I attended deceased from 6/8/39 to 6/10/39, 19...
I last saw him 6/10/39 alive on... Death is said to have occurred on the date stated above, at 6.30 a m.

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

Emphysema of Lungs 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) William Lippman, M. D.
(Address) City Hospital No. 1

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.

STATEMENT BY LICENSED EMBALMER

I,, Licensed Embalmer No.

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

..... L. E.

No. or by, Registered Apprentice No.

working under my personal supervision.

Signed *Albert Mayfield*

Licensed Embalmer No. *3077*

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.)