REC'D OCT 1 ...

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

31947
Do not use this space.

1. PLACE OF DEATH

(a) County Buchanan 3 Registration District No. 5

(b) Township or (c) City St Joseph Mo 1 Primary Registration District No. Registered No. 997

(d) Street No. St Hospital #2 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 yrs. 6 mos. 10 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 558 Leo N. Cunningham (Cunningham)

(a) Residence, No. State Hospital #2 St. Linn Co Mo.
(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 (write the word): married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Mar. 27, 1909

7. AGE: YEARS 30 | MONTHS 6 | DAYS 3 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: farm laborer
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): Livingston Co Mo.

FATHER
13. NAME: no information
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): ? o

MOTHER
15. MAIDEN NAME: Ellen ? 9
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Ill.

17. INFORMANT (ADDRESS): Mrs. Jennie Cunningham Wheeling Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE: Mt Olive Linn Co DATE: Oct 2, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS): F. L. Smiley Wheeling Mo

20. FILED: 9-30, 1939 K. J. Westlebush Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): Sept. 30, 1939

22. I HEREBY CERTIFY, That I attended deceased from Apr. 20, 1939, to Sept. 30, 1939
I last saw him alive on 11, 11, 1939. Death is said to have occurred on the date stated above, at 8-10 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Intestinal obstruction with perforation	9/20/39
Has had Parkinsonian syndrome since acute encephalitis (following influenza) one year previous	

Other contributory causes of importance:

Name of operation: exploratory Date of: 9/28/39
What test confirmed diagnosis? clinical 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) T. T. O'Dell, M. D.
(Address) St. Joseph

(Licensed Embalmer's Statement on Reverse Side)

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.

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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 Frank L. Smiley, Registered Apprentice No. 470, working under my personal supervision.

Signed Frank L. Smiley

Licensed Embalmer No. 470

P. O. Address Wheeling VA

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.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

31947 X
Do not use this space.

1. PLACE OF DEATH
(a) County Buchanan Registration District No. 85
(b) Township Primary Registration District No. 1001 Registered No. 997
(c) City St Joseph (d) Street No. 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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Leo N. Cunningham
(a) Residence, No. St. ☑
(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 M
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word) m

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

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

7. AGE YEARS 30 MONTHS 6 DAYS 3 If LESS than 1 day, ...hrs. or ....min.

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.
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)

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

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 9-30, 1939 A J Nestlebush
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 30, 1939

22. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19....
I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at .....m.
The principal cause of death and related causes of importance were as follows:

Date of onset

Intestinal obstruction with perforation N.M.D. 1 Feb
Pros had Parkinsonian syndrome since acute

Other contributory causes of importance:
Encephalitis following influenza 1 yr previous

Name of operation Exploratory 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) T. G. O'dell, M. D.
(Address) St Joseph Mo

SUPPLEMENTARY

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

S-31947