

OCT 18 1939

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

33266

Do not use this space.

1. PLACE OF DEATH

(a) County

Platte
Marshall

Registration District No.

698

(b) Township

Primary Registration District No.

5927

(c) City

(d) Street No.

(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

(a) Residence, No.

(Usual place of abode, if no street address, write county or city)

St.

(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

Ola Leitchfield Cunn

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

May 2 1868

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

21

3

4

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

Farmer

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Platte Co Mo

FATHER MOTHER

13. NAME

John Cunn

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

Kentucky

15. MAIDEN NAME

Malissa W. Daniel

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

Kentucky

17. INFORMANT (ADDRESS)

Rachel Cunn Weston Mo

18. BURIAL, CREMATION, OR REMOVAL

PLACE

DATE

West Beloit

9-8-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS)

J. B. Hill Weston Mo

20. FILED

9/7/39

J. B. Hill

Local Registrar

MEDICAL CERTIFICATE OF DEATH

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

Sept 6 1939

22. I HEREBY CERTIFY, That I attended deceased from

7-6-39, to 9-6-39

I last saw him alive on 9-4-39. Death is said

to have occurred on the date stated above, at 10 P. m.

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

Cerebral Hemorrhage

Date of onset

6-15-39

Other contributory causes of importance:

Diabetes Mellitus 1936

Name of operation

None

Date of

What test confirmed diagnosis? None 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

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) Frank E. Dehaene M. D.

(Address)

Weston, Mo.

RECEIVED

District Health Officer No. 11,

District File Number 1039-1281

Date Filed OCT-11-1939

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.