

Dr. Finigan 12-19-39

State File No. _____

Registration District No. 65-1

Primary Registration District No. 4388

Registrar's No. 123

1. PLACE OF DEATH:

(a) County Camden
(b) City or town Camden
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2
In this community 20 years
years, months or days (Specify whether)

3. (a) PRINT FULL NAME May Cunningham

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife John Cunningham 6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased 12-20-1872
(Month) (Day) (Year)

8. AGE: Years 66 Months 11 Days 25 If less than one day hr. _____ min. _____

9. Birthplace Bloomfield, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business _____
12. Name D. K.
13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name F. J.
15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Marjorie Meredith
(b) Address Camden, Mo.

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation maple cemetery

18. (a) Signature of funeral director J. R. Finigan
(b) Address Camden, Mo.

19. (a) Dec. 28, 1939 (b) Ada Martin
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Camden
(c) City or town Camden
(If outside city or town limits, write "RURAL")
(d) Street No. West 1st St.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 15
year 1939 hour 10 minute _____ A. M.

21. I hereby certify that I attended the deceased from Dec. 1 - 1939, to Dec. 15 - 1939;

that I last saw her alive on Dec. 15 - 1939 and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia Duration 3 days

Due to Influenza 14 days

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature J. R. Finigan (M. D. or other) _____

Address Camden, Mo. Date signed 12-19-39

MARGIN RESERVED FOR BINDING

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

50M-5-17-39
Rev. 5-17-39
1 x 1931

RECEIVED

District Health Officer No. 3,

District File Number 140-806

Date Filed 1/19/40

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.