

Registration District No. ~~123~~ <sup>123</sup> Primary Registration District No. ~~5467~~ <sup>5457</sup> Registrar's No. <sup>99</sup>

39  
0  
0  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:  
(a) County GREENE  
(b) City or town Willard Route I  
(c) Name of hospital or institution: 1 Cass St  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 48 years years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Greene  
(c) City or town Willard  
(If outside city or town limits, write "RURAL")  
(d) Street No. R. Route I (If rural, give location)  
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME JAMES P. CUNNINGHAM  
(b) If veteran, name war no  
(c) Social Security No. none

20. DATE OF DEATH: Month Aug day 15 year 1942 hour 10 minute 5 P. M.

21. I hereby certify that I attended the deceased from Oct, 1939, Aug 15, 1942 that I last saw him alive on Aug 30, 1942 and that death occurred on the date and hour stated above.

4. Male 5. Color of White  
6. (a) Single, widowed, married, divorced Widower  
6. (b) Name of husband or wife Widower  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years.

7. Birth date of deceased March 18 1859  
(Month) (Day) (Year)

Immediate cause of death Coronary Arteriosclerosis  
Due to Arteriosclerosis

8. AGE: Years 83 Months 4 Days 27 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) 940

9. Birthplace South Carolina  
(City, town, or county) (State or foreign country)  
10. Usual occupation Farmer  
11. Industry or business Retired Merchant  
12. Name Joseph Henry Cunningham  
13. Birthplace South Carolina  
(City, town, or county) (State or foreign country)  
14. Maiden name Betsy Falk  
15. Birthplace South Carolina  
(City, town, or county) (State or foreign country)

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

16. (a) Informant Mrs E Ethel Funder  
(b) Address Springfield MO  
17. (a) Burial (b) Date thereof Aug 17-1942  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Robbsey Park  
18. (a) Signature of funeral director J. W. Ferguson & Co  
(b) Address Springfield MO  
19. (a) 8119 1/2 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

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 [Signature] (M. D. or other) \_\_\_\_\_  
Address [Address] Date signed 8-16-42

RECEIVED

Greene County Health Office,

County File Number 42-9-27

Date Filed 9/1/42

207

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

*Max Rhodes*

Licensed Embalmer No.

*4071*

P. O. Address

*Springfield*

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, fact should be so stated above.