No. 2
-4-41
17-39
X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 37855

FILED DEC 8 1943

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 393

1. PLACE OF DEATH:

(a) County Callaway

(b) City or town Fulton (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hospital No 2 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 yrs 4 M 16 (Specify whether years, months or days)

In this community yes

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Marion 014

(c) City or town Palmyra (If outside city or town limits, write "RURAL")

(d) Street No. County Infirmary (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Ora Cunningham

3. (b) If veteran, name war DK.

3. (c) Social Security No. DK

4. Sex Female 3

5. Color or race Negro

6. (a) Single, widowed, married, divorced 2

6. (b) Name of husband or wife Sam Cunningham

6. (c) Age of husband or wife if alive Deceased years

7. Birth date of deceased DK (Month) (Day) (Year)

8. AGE: Years 82 | Months | Days | If less than one day ___ hr. ___ min.

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

10. Usual occupation None

11. Industry or business

FATHER
12. Name DK
13. Birthplace DK (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name DK
15. Birthplace DK (City, town, or county) 9 (State or foreign country)

16. (a) Informant Record

(b) Address

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 3 -43 (Month) (Day) (Year)

(c) Place: burial or cremation Robinson Cem

18. (a) Signature of funeral director Geo E Roberts

(b) Address Hannibal Mo

19. (a) Nov. 30-1943 (Date received local registrar) (b) Josie Mousnet Hoff (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 28 year 1943 hour 8-15 minute a M.

21. I hereby certify that I attended the deceased from 11/1/1943, to 11/28/1943 that I last saw him alive on 11/27/1943 and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis

Due to Arteriosclerosis

Due to

Other conditions (Include pregnancy within 3 months of death) 930

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature George W Reeves (M. D. or other)

Address Fulton Mo Date signed 11/29/43

(Licensed Embalmer's Statement on Reverse Side)

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 Geo E Roberts

Licensed Embalmer No. 2113

P. O. Address Hannibal Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
—5-43
I X38930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Dec

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 393

1. PLACE OF DEATH:

(a) County Callaway

(b) City or town Fulton
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State ..... (b) County .....

(c) City or town .....
(If outside city or town limits, write "RURAL")

(d) Street No. .....
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME Ora Cunningham

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex F

5. Color or race C

6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife .....

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased — (Month) (Day) (Year)

8. AGE: Years 82 Months — Days — If less than one day ..... hr. ..... min.

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

10. Usual occupation .....

11. Industry or business .....

FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)

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

16. (a) Informant .....
(b) Address .....

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

18. (a) Signature of funeral director .....
(b) Address .....

19. (a) ..... (Date received local registrar) (b) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 28
year 1943 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ....., 19.... to ....., 19....;
that I last saw h..... alive on ....., 19....;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions ..... (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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

23. Signature ..... (M. D. or other) .....
Address ..... Date signed .....

SUPPLEMENTARY

37855