

FILED FEB 18 1944

Registration District No. _____

Primary Registration District No. **3000**

Registrar's No. **21**

1. PLACE OF DEATH:

(a) County **Adair**
 (b) City or town **Kirkville**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Grim-Smith Hospital & Clinic
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **5 days**
(Specify whether years, months or days)
 In this community **6 years**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Adair**
 (c) City or town **Kirkville**
(If outside city or town limits, write "RURAL")
 (d) Street No. **1409 S. Porter**
(If rural, give location)
 (e) Citizen of foreign country? **No.** (Yes or No)
 If yes, name country *******

3. (a) PRINT

FULL NAME **Jimita Lee Cunningham**

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

4. Sex **Female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced ***** 0**

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

7. Birth date of deceased **May 31, 1937**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
6 7 14 hr. min.

9. Birthplace **Kirkville, Mo.** (City, town, or county) (State or foreign country) **0**

10. Usual occupation **school**

11. Industry or business ******

12. Name **James Cunningham**

13. Birthplace **Adair Co. Missouri**
(City, town, or county) (State or foreign country)

14. Maiden name **Juanita Scobee**

15. Birthplace **Adair Co. Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Juanita Scobee Nicoli**

(b) Address **Kirkville, Mo.**

17. (a) **Burial** (b) Date thereof **1/17/44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Ownbey Cemetery**

18. (a) Signature of funeral director **F. E. Grim**

(b) Address **Kirkville, Mo.**

19. (a) **1/22/44** (b) **Mrs. J. D. Wagoner**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **January** day **15**
 year **1944** hour **7** minute **45** P: M.

21. I hereby certify that I attended the deceased from **January 10, 1944** to **January 15, 1944**;

that I last saw her alive on **January 15, 1944**;

and that death occurred on the date and hour stated above.

Immediate cause of death **Encephalitis**

Duration **7 days**

Due to **measles** **2 wks**

Due to _____

Other conditions **35**
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy **not done**

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?

While at work? ****** (Specify type of place) (e) Means of injury **6** ******

23. Signature **George E. Grim M.D.** (M. D. or other)

Address **Kirkville, Mo.** Date signed **1/17/44**

AUG 4 1948

RECEIVED

District Health Officer No. 10

District File Number 2-44-305

Date Filed FEB. 5 1944

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 *J. E. Kelly*

Licensed Embalmer No. 4181

P. O. Address Winkville MD

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.