DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 24561

Registration District No. FILED JUL 20 1944 Primary Registration District No. 5419 Registrar's No. 8

1. PLACE OF DEATH:
(a) County Dunklin
(b) City or town Clarkton "Rural"
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Freeman Sta
(If not in hospital or institution, write street number or location) 1
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Dunklin
(c) City or town Clarkton Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 35
(If rural, give location) 8
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Mary Ann Cunningham
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Female
5. Color or race W
6. (a) Single, widowed, married, divorced Wid
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Nov (Month) 8 (Day) 1873 (Year)
8. AGE: Years | Months 7 | Days 10 | If less than one day hr. min.
9. Birthplace Campbell (City, town, or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name Brannon Cunningham
13. Birthplace Charitherville (City, town, or county) Mo (State or foreign country)
14. Maiden name Necia Freeman
15. Birthplace Mo (City, town, or county) (State or foreign country)
16. (a) Informant Brannon Cunningham
(b) Address Clarkton, Mo. R.1
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-19-44 (Month) (Day) (Year)
(c) Place: burial or cremation Gravel Hill, Ark
18. (a) Signature of funeral director Landers Funeral Home
(b) Address Campbell, Mo
19. (a) June 19, 1944 (Date received local registrar) (b) LaVonne Dunn (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 18 year 1944 hour 7 minute 7:30 A.M.
21. I hereby certify that I attended the deceased from May 13, 1944, to May 13, 1944, that I last saw her alive on May 13, 1944, and that death occurred on the date and hour stated above.

Immediate cause of death Lobar pneumonia — Duration
Due to
Due to
Other conditions (Include pregnancy within 3 months of death) 10 d
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 Dr. B. L. Franklin (M. D. or other)
Address Date signed

1249 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No
District File Number 744-
Date Filed 7-20-

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 Christina M. Landers

Licensed Embalmer No. 4227

P. O. Address Campbellsville M

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

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 24561

Registration District No. 105 Primary Registration District No. 5419 Registrar's No. 8

1. PLACE OF DEATH:

(a) County Franklin

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

(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 (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 Mary Ann Cunningham

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Nov. (Month) 8 (Day) 1943 (Year)

8. AGE: Years | Months 7 | Days 0 | If less than one day hr. min.

9. Birthplace (City, town, or county) Mo. (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 May day 8 year 1944 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 Dr. B. J. Franklin (M. D. or other) D.O.

Address Campbell, Mo. Date signed

SUPPLEMENTARY

WRITE PLAINLY—USE ONE DIAGRAM