

**FILED** JUL 28 1945

Registration District No. **318** Primary Registration District No. **1003**

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

**1. PLACE OF DEATH:**

(a) County St. Louis mo

(b) City or town St. Louis mo  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Enroute to Home Phillips  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether)

In this community abt 3 yrs 3  
years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State mo (b) County 17

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

(d) Street No. 3644 Cook Ave 11  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** A. Cleon Cunningham

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

3. (c) Social Security No. 329-224355

4. Sex Female 5. Color or race negro

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

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

7. Birth date of deceased April 27 1909  
(Month) (Day) (Year)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month July day 18th  
year 1945 hour 7 minute 00P M.

21. I hereby certify that I attended the deceased from 7-18-45 to 7-18-45

that I last saw her alive on 7-18-45  
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
<input checked="" type="checkbox"/>	<u>36</u>	<u>2</u>	<u>21</u>	hr. _____ min. _____

Immediate cause of death Lobar pneumonia

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions none  
(Include pregnancy within 3 months of death)

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

10. Usual occupation Operator

11. Industry or business Welsh Co.

12. Name Jerry Adams

13. Birthplace Mississippi  
(City, town, or county) (State or foreign country)

14. Maiden name Mattie White

15. Birthplace Mississippi  
(City, town, or county) (State or foreign country)

16. (a) Informant Mattie Adams

(b) Address 3644 Cook Ave

17. (a) Shipping (b) Date thereof 7-20-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Goakona Miss

18. (a) Signature of funeral director Arthur Brock

(b) Address 3644 Emory Ave

19. (a) 1111 79 1945 (b) J. J. Bredeck  
(Date received local registrar) (Registrar's signature)

Major findings: none

Of operations \_\_\_\_\_

Of autopsy none

**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) \_\_\_\_\_  
(c) Means of injury \_\_\_\_\_

23. Signature Robert M. Scott (M. D. or other) \_\_\_\_\_  
Address 3007 Eastern Ave Date signed 7-19-45

**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.....

*Louis V. Watkins*

Licensed Embalmer No.....

*2842*

P. O. Address.....

*3644 Finney Ave*

**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.