

U.S. No. 2
FORM-5-43
Rev. 5-17-39
X 36671

FILED OCT 29 1945

Registration District No. **747**

Primary Registration District No. **1002**

Registrar's No. **4312**

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:
K. C. Osteo Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days
(Specify whether years, months or days)

In this community 25 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 1603 E. 73rd
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME LUCY CUNNINGHAM

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Fe. / 5. Color or race White

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

6. (b) Name of husband or wife Frank

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

7. Birth date of deceased Oct. 21, 1874
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 17
year 1945 hour 11 minute P. M.

21. I hereby certify that I attended the deceased from Oct. 14, 1945 to Oct. 17, 1945.
that I last saw her alive on Oct. 17, 1945.
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>70</u>	<u>11</u>	<u>26</u>	hr. min.

Immediate cause of death Cerebral Hemorrhage *Days*

Due to Hypertension

Due to Arteriosclerosis

Other conditions Chronic Endo-Carditis
(Include pregnancy within 3 months of death)

Major findings:
Of operations 92

Of autopsy _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

MOTHER FATHER

9. Birthplace Des Moines Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation Homemaker

11. Industry or business None

12. Name Unknown

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

14. Maiden name 9

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

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 _____

Signature A. B. Boyer D.O. (M. D. or other) _____
Address 1009 E 47th St. Mo. Date signed Oct 19, 1945

16. (a) Informant Mrs. John Raccagno

(b) Address 1603 E. 73

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/45
(Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill

18. (a) Signature of funeral director C. H. Blackman & Son, Inc

(b) Address Kansas City, Mo.

19. (a) 10-20-45 (Date received local registrar) (b) E. Waldine Holmes (Registrar's signature)

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

*Dr. A. B. Boyer
1009 E. 47th*

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 *H. O. Blackman*
Licensed Embalmer No. *3639*
P. O. Address *K. C. Mo*

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.