

7. S. No. 2
FORM-5-43
Rev. 5-17-39
I X35671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20217

FILED JUL 2 1946
Registration District No. 149

Primary Registration District No. 1002

State File No. _____
Registrar's No. 2738

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

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:
Osteopathic Hospital 11th Harrison
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 month
In this community 2 months (Specify whether years, months or days)

3. (a) PRINT FULL NAME John W. Cunningham
3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Deceased 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased March 7 1863
(Month) (Day) (Year)

8. AGE: Years 83 Months 3 Days 12 If less than one day _____ hr. _____ min.

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

10. Usual occupation Retired Farmer

11. Industry or business _____

12. Name Cunningham

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

14. Maiden name Unknown

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

16. (a) Informant Mrs. J. C. Krosser

(b) Address 414 E. Angus

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 6/19/46
(Month) (Day) (Year)

(c) Place: burial or cremation El Dorado Texas

18. (a) Signature of funeral director Byrd Sumner Howell

(b) Address 200 So. State El Dorado Texas

19. (a) 6-30-46 (Date received local Registrar) (b) Thereldine Holme (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Kansas (b) County Stevens
(c) City or town Hugoton
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 6 day 19
year 1946 hour 5:15 minute A.M.
21. I hereby certify that I attended the deceased from May 22 1946 to June 19 1946
that I last saw him alive on June 18 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombus

Due to _____
Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 2

23. Signature M. S. Whitestone (M. D. or other) MD
Address Independence, Mo. Date signed 6/19/46

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

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

Raymond N Martin

Licensed Embalmer No.....

4150

P. O. Address

Indep. 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.