

No. 2
-12-45
5-17-39
K 47670

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **8999**
Registrar's No. **1563**

FILED APR 14 1947
Registration District No. **199**

Primary Registration District No. **1002**

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:
4640 MONTGALL AVENUE
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community **77 YEARS** (Specify whether years, months or days)

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. **4640 MONTGALL AVENUE**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Mrs LAURA E. CUNNINGHAM**
(b) If veteran, name war **No**
(c) Social Security No. **NONE**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **APRIL** day **3RD**
year **1947** hour **11** minute **45 A. M.**
21. I hereby certify that I attended the deceased from **12/26** 19**47**, to **4/3** 19**47**
that I last saw **her** alive on **4/3** 19**47**
and that death occurred on the date and hour stated above.

4. Sex **FEMALE** 5. Color or race **WHITE**
6. (a) Single, widowed, married, divorced **WIDOWED**
6. (b) Name of husband or wife **MR. WILLIAM W. CUNNINGHAM**
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **MAY 26 1869**
(Month) (Day) (Year)

Immediate cause of death **Cerebral Hemorrhage** Duration **3 Days**
Due to **arterio Sclerosis** **3 yr**
Due to _____
Other conditions **Chronic Myocarditis** **5 yrs.**
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day
77 10 29 hr. min.

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

9. Birthplace **KANSAS CITY MISSOURI**
(City, town, or county) (State or foreign country)

10. Usual occupation **AT HOME**

11. Industry or business _____

MOTHER FATHER
12. Name **X. X. BUCKNER**
13. Birthplace **UNKNOWN KENTUCKY**
(City, town, or county) (State or foreign country)
14. Maiden name **CLARA BATES JOHNSTONE**
15. Birthplace **UNKNOWN KENTUCKY**
(City, town, or county) (State or foreign country)

16. Informant **John M. Gunn, Jr.**
Address **4640 Montgall**

17. (a) **BURIAL** (b) Date thereof **APR-5-1947**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **FOREST HILL CEMETERY**

18. (a) Signature of funeral director **D. H. Newcomer, Sons**
(b) Address **1401 BRUSH CREEK BLDG.**

19. (a) **4-5-47** (b) **Sheraldine Holmes**
(Date received local registrar) (Registrar's signature)

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 **0**
23. Signature **D. H. Newcomer** (M. D. or other)
Address **900 Rialto Bldg** Date signed **4/4/47**

900
12.3
Specialty Body

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 Melvin Miller
Licensed Embalmer No. 4407
P. O. Address Kansas City 3, 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.