

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **27623**
7214
Registrar's No.

FILED AUG 28 1948
Registration District No. **518**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County.....
(b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer G Phillips
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 mos; 17 days
(Specify whether
In this community 30 yrs
years, months or days)

3: (a) PRINT FULL NAME Joe Cunningham

3. (b) If veteran, name war..... 3. (c) Social Security No.

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased March 16 1896
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
55 4 28 hr. min.

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

10. Usual occupation Nil

11. Industry or business.....

12. Name Penny Cunningham
13. Birthplace Unk Miss
(City, town, or county) (State or foreign country)
14. Maiden name Unk
15. Birthplace Unk Miss
(City, town, or county) (State or foreign country)

16. (a) Informant St Jenkins
(b) Address Homer G Phillips Hospital

17. (a) Burial (b) Date thereof AUG 19 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park Cem.

18. (a) Signature of funeral director Boyd Bros. Fun Home
(b) Address 2704 FINNEY AVE.

19. (a) AUG 17 1948 (b) J. F. Brodeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County bood
(c) City or town St Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4935 Page
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 14
year 1948 hour 1 minute P M.

21. I hereby certify that I attended the deceased from May 28, 19 48 to August 14, 19 48
that I last saw him alive on August 14, 19 48
and that death occurred on the date and hour stated above.

Immediate cause of death.
Hypertensive Heart Disease
Cerebral Vascular Hemorrhage

Due to.....
Due to.....

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

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.....

23. Signature J. Daniels (M. Doctor)
Address 2601 N Whittier Date signed 8-16-48

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

Edward A Flynn

Licensed Embalmer No.

4444

P. O. Address

4548 1/2 Page Blvd

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.

Ln 7664