

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 35089  
Registrar's No. 2466

FILED NOV 9 1948  
Registration District No. 27

Primary Registration District No. 6076

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

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:  
Robert Koch Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 92 days  
(Specify whether years, months or days)

In this community 40 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County oac

(c) City or town St. Louis 17  
(If outside city or town limits, write "RURAL")

(d) Street No. 3150 Brantner Place 9  
(If rural, give location)

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

3. (a) PRINT FULL NAME CUNNINGHAM, ELVIN

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

3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 2 5. Color or race Negro

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

6. (b) Name of husband or wife Helen Taylor Cunningham alive \_\_\_\_\_ years

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

7. Birth date of deceased July 17 1900  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>48</u>	<u>3</u>	<u>6</u>	_____ hr. _____ min.

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

10. Usual occupation Molder

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Edward Cunningham

{ 13. Birthplace Milan Tenn.  
(City, town, or county) (State or foreign country)

{ 14. Maiden name Amanda Moore

{ 15. Birthplace Milan Tenn.  
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital Records

(b) Address Robert Koch Hospital

17. (a) Burial (b) Date thereof: 10/27/48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Saint Peters Cemetery

18. (a) Signature of funeral director Charles J. Gates

(b) Address 4107 Finney Avenue

19. (a) 10-23-48 (b) Beverly Thompson  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 23  
year 1948 hour 12 minute 50 A. M.

21. I hereby certify that I attended the deceased from 7-23-48, 19\_\_\_\_, to 10-23-48, 19\_\_\_\_;  
that I last saw him alive on 10-23-48, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis 3 yrs.  
(??)

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

Due to 13 b

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

PHYSICIAN

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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)

(e) Means of injury \_\_\_\_\_

23. Signature Bernard Friedman (M. D. or other) MD

Address Robert Koch Hospital Date signed 10/23/48

SEP 17 1949

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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 \_\_\_\_\_

Licensed Embalmer No. 4509

P. O. Address 4107 7<sup>th</sup>

**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.