

FILED APR 8 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
318

State File No. 9931

BIRTH NO. 48-82778 REG. DIST. NO. PRIMARY REG. DIST. NO. 1003 Registrar's No. 2913

1. PLACE OF DEATH a. COUNTY Mo.		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo.	
b. CITY (If outside corporate limits, write RURAL and give township) Dr. Lewis		b. COUNTY	
c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) Dr. Lewis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Hos P = 20		d. STREET ADDRESS 2911 Kelman	

3. NAME OF DECEASED (Type or Print) Gabriel			b. (Middle) Cunningham			c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) Mar. 21 1949		
5. SEX Male			6. COLOR OR RACE Negro			7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify)			8. DATE OF BIRTH 1949		
9. AGE (In years, if under 1 year last birthday) Months Days			10. USUAL OCCUPATION (Give kind of work done during usual working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) St. Louis Mo		
12. CITIZEN OF WHAT COUNTRY U.S.A.			13a. FATHER'S NAME Wm K			13b. MOTHER'S MAIDEN NAME Wm K			14. NAME OF HUSBAND OR WIFE Wm K		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or not known) (If yes, give war or date of service)			16. SOCIAL SECURITY NO. Wm K			17. INFORMANT'S SIGNATURE OR NAME Dorothy C. Taylor			ADDRESS 1300 Park		
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		Bilateral							
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES							
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.						atelectasis	
		DUE TO (b)							
		DUE TO (c)						Hem	
		II. OTHER SIGNIFICANT CONDITIONS							
		Conditions contributing to the death but not related to the disease or condition causing death.						two	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION two						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					

22. I hereby certify that I attended the deceased from 19 to 19, that I last saw the deceased alive on 19, and that death occurred at 1300 Park from the causes and on the date stated above.

23a. SIGNATURE Joseph W. Quinn		(Degree or title) Deputy Registrar		23b. ADDRESS 1300 Clark		23c. DATE SIGNED 3/28/49	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE MAR 31 1949		24c. NAME OF CEMETERY OR OPERATORY Anatomical Board		24d. LOCATION (City, town, or county) (State)	

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE MAR 31 1949 J. B. Lassiter		25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service 4104 Manchester Ave.					
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

..... Student Embalmer No.

working under my personal supervision.

Signed.....

Signed.....
Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

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.