

FILED JUN 2 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15052

BIRTH NO. _____ REG. DIST. NO. 47 PRIMARY REG. DIST. NO. 3008 Registrar's No. 185

1. PLACE OF DEATH a. COUNTY Callaway		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY St Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Fulton		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location) 2840 Walnut St	

3. NAME OF DECEASED (Type or Print) a. (First) James b. (Middle) - c. (Last) Cunningham			4. DATE OF DEATH (Month) (Day) (Year) May 23 1949					
5. SEX Male 2	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH D. K.	9. AGE (In years last birthday) 49 ?	IF UNDER 1 YEAR Months	IF UNDER 12 HRS. Days	IF UNDER 12 HRS. Hours	IF UNDER 12 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Miss		12. CITIZEN OF WHAT COUNTRY? U.S. A.		

13a. FATHER'S NAME D. K.		13b. MOTHER'S MAIDEN NAME D. K.		14. NAME OF HUSBAND OR WIFE M			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Hospital records		ADDRESS	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Occlusion.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden death.</u>
	II. OTHER SIGNIFICANT CONDITIONS* Conditions contributing to the death but not related to the disease or condition causing death.		
ANTECEDENT CAUSES Aforbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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 sudden, 19 , to , 19 , that I last saw the deceased alive on May 21, 1949, and that death occurred at m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>MJ Miller MD</u>		23b. ADDRESS State Hospital, Fulton, Mo		23c. DATE SIGNED 5-23-1949
24a. BURIAL CREMATION, REMOVAL (Specify) <u>Removed</u>	24b. DATE <u>5-26-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>anatomical</u>	24d. LOCATION (City, town, or county) (State) <u>Columbia Mo</u>	
DATE REC'D BY LOCAL REG <u>May 26-1949</u>	REGISTRAR'S SIGNATURE <u>Maretha Lawrence</u>	426	25. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Robaste</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
District Health Officer No. 9,
District File Number _____
Date Filed JUN 1 1949

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.

Student _____
Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply
the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.