

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

7463

State File No. ....

1594

FILED FEB 26 1953

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. <u>1594</u>	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS,</u>		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS,</u>		<u>2109</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>3117 NO. NEWSTEAD AVE</u>				d. STREET ADDRESS (If rural, give location) <u>10 3117 NO. NEWSTEAD AVE</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>CHARLES</u>		b. (Middle) <u>R.</u>		c. (Last) <u>CUNNINGHAM</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>2/9/53</u>	
5. SEX <u>MALE</u> <u>0</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>12/17/1864</u>		9. AGE (In years last birthday) <u>88</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>ILLINOIS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>UNKNOWN</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>ANNA CUNNINGHAM</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>ELIZABETH CHRISTOPHEL 4229 W. LEXINGTON</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>CHRONIC MYOCARDITIS</u>  ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>BRONCHIAL ASTHMA</u> II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i> <u>CHRONIC BRONCHITIS</u>				INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs</u> <u>years ?</u> <u>years ?</u> <u>Years ?</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>241X</u>			
22. I hereby certify that I attended the deceased from <u>Jan. 19 20</u> , 19 <u>20</u> , to <u>Feb. 9</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>Feb. 8</u> , 19 <u>53</u> , and that death occurred at <u>6 A.</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>R. M. Gevain</u>		(Degree or title) <u>M.D.</u>		23b. ADDRESS <u>4356 Warne Avenue</u>		23c. DATE SIGNED <u>2-10-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>2/11/53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>CALVARY CEMETERY</u>		24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MISSOURI</u>		
DATE REC'D BY LOCAL <u>FEB 10 1953</u>		REGISTRAR'S SIGNATURE <u>Charles Smith MO</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>STROOT - CARROLL 4600 NATURAL BRIDGE</u>			

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.

Student .....

Student Embalmer

Signed

*Albert Mayfield*

Licensed Embalmer No. *3077*

P. O. Address *St. Louis 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.