

FILED APR 26 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

13334

State File No. \_\_\_\_\_  
Registrar's No. **3212**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE		b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN <b>St. Louis</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Faith Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>21 2421a Cass Ave.</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Sylvester</b>		b. (Middle) <b>(George) J.</b>		c. (Last) <b>Cunningham</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>April 8th 1954</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, SEPARATED <b>Never married</b>		8. DATE OF BIRTH <b>January 1st 1888 66</b>		9. AGE (In years last birthday) (If under 1 year: Months) (If under 12 months: Days) (If under 12 hours: Hours) (If under 15 min.: Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Park</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis Mo.</b>		12. CITIZEN OF WHAT COUNTRY?	

13a. FATHER'S NAME <b>John Cunningham</b>		13b. MOTHER'S MAIDEN NAME <b>Elizabeth Delaney</b>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year of entry of service) <b>Yes WWI</b>		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME <b>William Sullivan 3326 Coles Ave</b>	

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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <b>Cardio-vascular heart disease</b>		?	
		DUE TO (c) <b>Hypertension, mild</b>		?	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" 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) <b>443-K</b>	
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?	

22. I hereby certify that I attended the deceased from **4-8-54** 19, to **4-8-54**, 19, that I last saw the deceased alive on **4-8-54**, 19, and that death occurred at **5:25 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Anthony V. Benvenuto MD</b>		23b. ADDRESS <b>3731 Goodfellow Blvd</b>		23c. DATE SIGNED <b>4-8-54</b>	
24a. BURIAL, CREMATION, REMAINS (Specify)		24b. DATE <b>4/10/54</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Calvary</b>	
				24d. LOCATION (City, town, or county) (State) <b>St. Louis Mo.</b>	

DATE REC'D BY LOCAL REG. <b>APR 9 1954</b>		REGISTRAR'S SIGNATURE <b>J. Paul Smith MD</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Sullivan's 2849 N. Euclid Ave.</b>	
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(Licensed Embalmer's Statement on Reverse Side)

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

APR 27 1955

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 .....  
Signature of Student Embalmer

Signed *Albert Mayfield* .....  
Licensed Embalmer No. *307* .....  
P. O. Address *St Louis* .....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.