

No. 300  
10.48

FILED FEB 7 - 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **145**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **38** PRIMARY REG. DIST. NO. **3006** Registrar's No. **28**

1. PLACE OF DEATH a. COUNTY <b>Boone</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Boone</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Columbia</b>		c. LENGTH OF STAY (in this place) <b>2 1/2 days</b>	c. CITY OR TOWN <b>Columbia</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Boone County Hospital</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
STREET ADDRESS <b>814 Maupin Road</b>		<b>01050</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Ella</b>	b. (Middle) <b>Sanford</b>	c. (Last) <b>Cunningham</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Jan. 30, 1955</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>July 7, 1868</b>	9. AGE (In years last birthday) <b>86</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Warsaw, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Jim Sanford</b>	13b. MOTHER'S MAIDEN NAME <b>Nancy Sapp</b>	14. NAME OF HUSBAND OR WIFE <b>Deceased W. P. Cunningham</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>-----</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Jewell C. Cunningham</b>	ADDRESS <b>Columbia, Mo.</b>
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Uremia</b>		Antecedent Causes Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) <b>arteriolar nephrosclerosis</b> <b>unknown</b>  DUE TO (c) _____
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Cerebral arteriosclerosis</b> <b>unknown</b>		

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>
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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>440 X</b>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) _____	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 **1-22**, 19**55**, to **1-30**, 19**55**, that I last saw the deceased alive on **1-29**, 19**55** and that death occurred at **7:35a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Charles M. Fank</b>	23b. ADDRESS <b>Columbia, Missouri</b>	23c. DATE SIGNED <b>1-31-55</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>2/1/1955</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>	24d. LOCATION (City, town, or county) (State) <b>Columbia, Mo.</b>
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DATE REC'D BY LOCAL REG <b>Jan 31 1955</b>	REGISTRAR'S SIGNATURE <b>Mrs R.E. Palmer</b>	31-0	FUNERAL DIRECTOR'S SIGNATURE <b>Memorial Funeral Home</b>	ADDRESS <b>Columbia, Mo.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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, ~~\_\_\_\_\_~~ ....., Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Lynnan H. Spunk*

Licensed Embalmer No. *4013*  
P. O. Address *Columbia*

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.